3.0 SCOPE OF WORK

3.1 GENERAL CONTRACTOR'S RESPONSIBILITIES

The Contractor shall have the following general responsibilities:

Educate beneficiaries and other interested parties regarding the State's managed care program, managed care concepts, and enrollment options. Ensure beneficiaries are appropriately enrolled or disenrolled into health plans in accordance with State HCO policy. Ensure beneficiaries receive culturally and linguistically appropriate information about managed care, the participating plans, their providers, and their rights and responsibilities as a managed care member.

Implement the HCO program in a timely and uniform manner in new, existing, and future counties as designated by the State.

Provide and operate an appropriate and cost-effective enrollment system and process. Provide an effective data reporting system regarding informing, enrollment and disenrollment, customer assistance, and other HCO activities as described in this RFP.

The Contractor shall use the following definitions to describe the requirements of performance throughout Operations and its subsections:

1. All letters, notices and written materials or information to be provided to beneficiaries must meet the standards as described in Development of Materials – Standards for Materials (Subsection 3.3.2.1(3)), unless otherwise stated.

2. The timeliness requirement for letters, notices and other written materials or information to be mailed, sent, returned to beneficiaries or others as specified shall be measured using the date the document was delivered to the USPS or other authorized carrier, unless otherwise stated.

3.1.1 Other Pilot Programs

During the term of this contract the State may direct the Contractor to provide HCO services for pilot programs. The pilot project plans will be offered as an alternative managed care option to Medi-Cal beneficiaries who reside within the service area of the pilot project. However, unlike the other plan options, enrollment may be strictly voluntary.

3.2 DATA RECEIPT AND PROCESSING

3.2.1 MEDI-CAL ELIGIBILITY DATA SYSTEM

The Medi-Cal Eligibility Data System (MEDS) is the State's automated eligibility data collection system. The MEDS database contains approximately 20 million active and inactive beneficiary records. Each month, an average of 5 million beneficiaries are eligible for Medi-Cal. More detailed information on MEDS records and processing, including the MEDS User Manual, record layouts, and Data Element Dictionary, is available in the OMCP data library.

MEDS is available 7 days a week, 22 hours a day, except for regularly scheduled system maintenance. The hours of operation for the on-line MEDS system are from 2 A.M. to midnight Pacific Time. This schedule is subject to change based on the needs of the State. During these hours, the Contractor may submit HCO enrollment/disenrollment batch files and on line enrollment/disenrollment transactions.

3.2.2 ASSUMPTIONS AND CONSTRAINTS

A beneficiary's Medi-Cal and health care enrollment eligibility is subject to the following assumptions and constraints:

1. An applicant may become an eligible Medi-Cal beneficiary at any time during the month. However, the onset date of eligibility shall be the first day of that calendar month and termination of Medi-Cal eligibility shall be at the end of a calendar month only.

2. A beneficiary may be eligible for Medi-Cal one month, ineligible for the next month, etc., as determined by the county welfare department or the Social Security Administration.

3. A beneficiary, while retaining their Medi-Cal eligibility, may lose their ability to be enrolled in a health care plan for a period of time. This health care "hold status" is a result of a change in eligibility status or a change in one or more recipient data elements that has an effect on plan enrollment, i.e. change in aid code, zip code, county code, other health coverage, etc. The "hold status" for the beneficiary may or may not be removed.

4. A beneficiary identification number may change. As a beneficiary may be identified by more than one ID number, these numbers must be crossed-referenced using data provided by the State.

5. MEDS is updated with beneficiary Medi-Cal and health care plan eligibility information on a nightly basis.

6. One or more beneficiaries may be linked together to form a Medi-Cal case.

   The Medi-Cal case is identified as follows:

   One of the beneficiary identifiers used by the MEDS system is county identification. The county identification field consists of the county code, the aid code, serial number, family budget unit (FBU) and person number. Members of the same Medi-Cal case shall have the same county code, serial number and FBU. Typically, the "head of household" in the Medi-Cal case shall be the eldest member having the least current birth date. Usually, informing packets and other informational mailings shall be sent to the "head of household" for each Medi-Cal case.

7. The Medi-Cal month of eligibility (MOE) is from the first day of the calendar month to the last day of the calendar month. However, to allow time for month-end distribution of data, known as MEDS renewal, MEDS starts the new MOE approximately 6 to 8 days before the start of the new MOE. The date this process begins is known as MEDS cutoff. Data received after MEDS cutoff shall be processed for the following MOE month. For example, the MEDS data shall be "rolled" into October MOE on or after September 23rd.

8. Not all Medi-Cal beneficiaries are eligible to enroll in a health plan. A beneficiary's eligibility to enroll in a health care plan can be determined by several factors, such as county of residence or county of responsibility, aid code, zip code or other health coverage code. In addition, individual beneficiaries may have special exemptions that preclude their health plan enrollment. These health plan enrollment eligibility requirements may periodically change.

3.2.3 CONTRACTOR RESPONSIBILITIES

3.2.3.1 Communication Links

The Contractor shall establish and maintain through the term of this contract an agreement with the Health and Human Services Data Center (HHSDC) for appropriate links between the Contractor and HHSDC. These data links shall be used for computer access, both batch and on-line, to records contained in MEDS or any other beneficiary eligibility file made available to the Contractor, and to transmit and retrieve data files in a format to be determined by the

State. The Contractor shall also have the capability to evaluate the data received from the State and identify changes in beneficiary's qualifications for health care plan enrollment, and take appropriate action. The costs of installation, maintenance and monthly charges for this data line are the responsibility of the Contractor. Communication protocols, line configuration, communication software, etc. shall be determined by the State during Takeover.

The Contractor shall maintain the capability to communicate with the Department electronically. The Department currently uses Group Ware products for electronic communications. The current standard configuration for the Department's networked staff is Microsoft Exchange/Outlook for messaging and calendaring and Microsoft Office 97 for word-processing, spreadsheets, databases, presentations, etc. The Contractor must have the ability to receive and read files from this office suite of products as well as send files to the Department in a form readable and editable by these software applications.

The Contractor shall establish a method to allow electronic retrieval of data from and by Health Care Plans and other parties designated by the State.

The Contractor shall establish a method to allow electronic exchange of data with one or both of the state's California Medicaid Management Information System's fiscal intermediary contractors.

3.2.3.2 Changes to Medi-Cal Affecting MEDS

The Medi-Cal program is a very dynamic program frequently resulting in new medical and/or health care policy/coverage or changes in eligibility criteria or requirements. As a result, there are frequent updates and changes to the data requirements for MEDS. Most changes are considered maintenance, i.e. adding/deleting aid codes, adding/deleting health care plan codes, adding/deleting health care plan covered county or zip codes, adding/deleting status/disposition/transaction error codes. These types of modifications to the MEDS data are considered regular maintenance and the Contractor is required to implement these changes to their system at no additional cost to allow the timely and appropriate use of this data.

Some changes in policy, however, may constitute the creation of new files, changes to existing file structure or changes to the Contractor's automated system or systems. These latter changes to the Contractor's system shall be made in accordance with Change Requirements (Subsection 3.10.2.5).

The State shall facilitate regularly scheduled meetings with the Contractor to inform and plan modifications to MEDS, identify and resolve issues/problems between MEDS and the Contractor's system and maintain open

communication between the State and the Contractor regarding eligibility and data issues. Initially these meetings shall be weekly. This schedule may be modified based on the needs of the State. The Contractor shall make the appropriate people available to attend these meetings.

3.2.3.3 State Supplied Data Files

At a minimum, the State shall provide the Contractor with the following data files to assist in processing enrollment and disenrollment transactions:

1. Daily HCO File, which may contain newly active beneficiaries who have been designated a potential candidate for health care enrollment in a HCO county, and replacement records for any current, prior or potential candidate for health care enrollment in a HCO county whose MEDS data has recorded a change in one or more pertinent data field, or a change to a beneficiary record that could have an effect on plan enrollment.

   The Daily HCO file shall be made available to the Contractor by the State each day, Tuesday through Saturday (except for State holidays) by 6 a.m. Pacific Time. The Contractor shall retrieve this file the same business day by 10 a.m. Pacific Time, except Saturdays. The Saturday file shall be retrieved by 10 a.m. Pacific Time the following Monday.

2. HCO Transaction Log File, which shall provide the Contractor with the status of each enrollment or disenrollment transaction received from the Contractor and applied to the MEDS record of a Medi-Cal beneficiary or health plan enrollee in an HCO county. This file contains information required for the Contractor to identify and correct errors, and generate appropriate beneficiary confirmation mailings. This file contains a disposition code for each record received and processed by MEDS that indicates acceptance or rejection via a disposition code, and if rejected, a rejection reason code.

   a. The HCO Transaction Log file shall be made available to the Contractor by the State each day, Tuesday through Saturday (except for State holidays) by 6 a.m. Pacific Time the day following the submission of the transaction by the Contractor. The Transaction Log file for transactions submitted by the Contractor on a Saturday date will generally not be available until the following Monday unless an alternative arrangement is made three days in advance. The Contractor shall retrieve this file each business day by 10 a.m. Pacific Time, except Saturdays. The Saturday file shall be retrieved by 10 a.m. Pacific Time the following Monday.

b. The Contractor shall maintain an HCO Transaction disposition process tracking and resolving all rejected transactions. The Contractor shall submit to the state by the 10th of the month a list of all unresolved rejected transaction from the previous MEDS period (cut-off date to cut-off date).

3. Monthly Project Control Table, which contains current information on health care plan coverage, i.e. covered aid, county, zip and health care plan codes. The Contractor shall use this information to identify which health plans are available for enrollment in which county and zip code, for which beneficiary aid codes and for which enrollment periods. This file shall specify the date the plan was activated, deactivated, and the date the information was last changed for the individual health care plan.

   The Monthly Project Control Table shall be made available to the Contractor by the State two business days after the monthly MEDS renewal process is complete.

   The Contractor shall retrieve the Monthly Project Control Table within 24 hours after file availability and complete table/system synchronization within 48 hours after file availability.

4. Monthly Reconciliation File, which shall provide the Contractor with the current eligibility status of plan member and non-plan member Medi-Cal beneficiaries which meet the enrollment criteria in an HCO county. This file contains information that shall allow the Contractor to synchronize its' beneficiary eligibility file with MEDS. The information on this file is to be considered to be correct if there is a difference between the Contractor's system and MEDS.

   The Monthly Reconciliation File provides the status of each beneficiary as of the date of MEDS cut-off for the following month of eligibility and/or health plan enrollment (e.g. 8/24 MEDS cut-off for a 9/1 eligibility/health plan enrollment).

   The Monthly Reconciliation File shall be available two days after the monthly MEDS cut-off cycle is complete. The Contractor shall retrieve the Monthly Reconciliation File within 24 hours after file availability and complete their system synchronization by the first calendar day of the following month (e.g. 8/24 MEDS cut-off for a 9/1 eligibility/health plan enrollment).

5. Special Recipient Files, which shall be data files the Contractor shall accept and process as instructed by the State. These files shall be in

the same format as the Daily HCO file. The State and the Contractor shall negotiate an agreeable processing plan to perform the required activities. Since these special files shall result in additional enrollment transaction activity, it is assumed there shall be no additional payment to the Contractor except as provided for in the contract under Payment Provisions (Chapter 8.0). The types of special files anticipated are:

a. Redetermination – Monthly files generated as a by-product of the Medi-Cal beneficiary annual eligibility redetermination process (approximately 1/12 of the county's Medi-Cal population), generally used prior to a full county conversion to managed care to identify beneficiaries for potential enrollment into a health care plan. These files may be used to allow for a partial conversion prior to converting the whole county population.

b. Adding/Deleting Health Plan Contracts – The State contracts for services with individual health care plans for a set period of time under the various managed care models operated by the State. When one or more contracts ends or is terminated for cause, or is not renewed, or a new plan is added in a covered area, the State may need to notify beneficiaries of a change in plan availability. This file would contain those beneficiaries that would need to be notified and/or mailed enrollment material.

c. Special files – The State may have a need to generate special beneficiary files based on specific criteria for which the Contractor shall be instructed to mail special materials and/or beneficiary enrollment materials.

3.2.3.4 Contractor Supplied Data Files

On a daily basis, the Contractor shall generate an HCO enrollment/disenrollment transaction file to submit batch enrollment/disenrollment transactions to the State's MEDS for processing changes in the health care plan enrollment status for a Medi-Cal beneficiary. HCO enrollment/disenrollment transaction files received by 3 p.m. Pacific Time Monday through Friday (except State holidays) shall be processed by MEDS that night. To be included in that day's processing cycle, the file must be ready for processing by the cutoff time, not the time that the Contractor starts the transmission. Files shall be accepted seven days a week, but, unless prior approval is requested and approved, generally the State shall only process the files into MEDS Monday through Friday.

The Contractor shall transmit to the State the HCO enrollment/disenrollment transaction file containing pending changes in the health care plan status for Medi-Cal beneficiaries.

The Contractor shall submit the HCO enrollment/disenrollment transaction file in a format to be determined by the State.

Unless prior approval is requested and approved, the Contractor shall transmit only one (1) HCO enrollment/disenrollment transaction file each day. It is advised the Contractor negotiate a fixed transmission schedule with the State to assist in processing the file.

The MEDS on-line inquiry system is available to assist the Contractor to obtain beneficiary Medi-Cal eligibility and/or health care plan status and for researching why the batch enrollment transaction(s) did not process.

The MEDS on-line update system is only to be used for current month and retroactive disenrollment and emergency disenrollment processing. With prior permission from the State, the Contractor may use the MEDS on-line update system to process/enter enrollment transactions the day prior and the day of MEDS cut-off. However, any transactions that are processed on-line to MEDS does not relieve the Contractor of the responsibility for capturing and reporting the enrollment/disenrollment information in the HCO system. On-line MEDS transactions may only be entered by specifically authorized Contractor staff with the appropriate MEDS security level access.

Enrollments/disenrollments received and accepted by the State after the prior month's MEDS renewal date and before the next month's established MEDS renewal date will become effective the first day of the next month.

3.3 MATERIALS DEVELOPMENT AND PRODUCTION

3.3.1 OVERVIEW

The Contractor shall develop, translate and/or produce all written or audio-visual enrollment, informing and outreach materials used in the Health Care Options program except for Indian Health Clinic materials or any other materials specified by the State. Additionally, the Contractor must adhere to certain content and production standards in order to communicate effectively with Medi-Cal beneficiaries and to meet all applicable statutory and regulatory requirements.

Many of the materials specified below already have been developed and are currently in use. If the State determines that these materials are still accurate and appropriate, the Contractor need not develop new materials and shall produce the existing materials as currently written. However, at any time that

the State determines updates to existing materials, or new materials, are needed, the Contractor must develop and produce them in accordance with the requirements specified in below.

The State has established a DHS Medi-Cal Managed Care Advisory Group, composed of representatives of health plans and advocacy groups, as well as State representatives. The Contractor shall be responsible for establishing a relationship with this group, maintaining this relationship on an ongoing basis, and obtaining input from the group on all proposed new materials as well as significant updates to existing materials.

3.3.2 CONTRACTOR RESPONSIBILITIES

The Contractor shall employ staff of a sufficient number and with an appropriate level of expertise to oversee and facilitate material development, translation and production. Translation means to prepare all required materials not only in English but also in all other threshold languages, as specified by the State. The Contractor shall be responsible for performance of these activities, whether they are carried out by Contractor staff or by subcontractors.

3.3.2.1 Development of Materials

1. Existing Materials

   a. The Contractor shall update, translate and maintain all materials to be included in informing packets, as directed by the State, except for provider directories, Indian Health Clinic brochures, and any other materials that may be specified by the State. Informing packet materials for which the Contractor has update responsibility include, at a minimum:

      1) A cover letter explaining the Medi-Cal Managed Care Program, the decisions the beneficiary needs to make, the timeframe for the decision, and the consequences of not making a decision. The cover letter shall be one of two types. For beneficiaries in mandatory aid codes, the cover letter shall be the Intent to Assign letter. For beneficiaries in voluntary aid codes, the letter shall describe the beneficiary's options, including fee-for-service.

      2) Health plan model-specific information/instruction booklets, currently referred to as "My Medi-Cal Choice Booklet". The booklets explain the requirement to choose a plan, the importance of making a prompt

choice, the process for choosing a plan and completing the enrollment/disenrollment form, the assignment process applied to those who do not make a choice, and any other information the State may require. The Contractor also has update responsibility for the following materials, which shall be inserted in the inside pocket of the booklet before insertion into the informing packet:

a) The most recent county-specific presentation schedule as specified in Administration Support of HCO Presentation. This schedule lists Contractor sites or other locations where beneficiaries may attend a presentation explaining the choice process and materials included in the informing packet, which may change monthly.

b) A list of toll-free telephone numbers and addresses that the beneficiary can use to obtain additional culturally sensitive and linguistically appropriate assistance in selecting a plan and completing the enrollment/disenrollment form.

c) A county-specific list of important telephone numbers.

d) County-specific plan comparison chart(s) that illustrates the similarities and differences between health plans.

e) A Medical or Non-medical Exemption form.

f) A post card that the beneficiary may use to request a new informing packet in the event he/she wishes to obtain a packet in another language, change plans or disenroll, if permitted.

g) A postage-paid envelope for the beneficiary's use in returning the enrollment/disenrollment form.

h) A printed envelope containing dental informing materials, in counties requiring mandatory dental managed care. The materials in this envelope, which shall be developed and produced by the Contractor in accordance with Materials Development and Production, shall contain comparison charts and any other required

information. Currently, only Sacramento County is a mandatory dental managed care county.

i) A Health Care Planner.

3) Medical enrollment/disenrollment forms.

4) Voluntary Dental plan model-specific information/instruction booklets currently referred to as the Dental "My Medi-Cal Choice Booklet". The booklets explain how to use Medi-Cal Dental Managed Care Plans. The Contractor also has update responsibility for the following materials, which shall be inserted into the inside pocket of the booklet before insertion into the informing packet:

a) The insert describing the process for choosing a dental plan and completing the enrollment/disenrollment form

b) The most recent county-specific presentation schedule as specified in Administration Support of HCO Presentation. This schedule lists Contractor sites or other locations where beneficiaries may attend a presentation explaining the choice process and materials included in the informing packet, which may change monthly.

c) A list of toll-free telephone numbers and addresses that the beneficiary can use to obtain additional culturally sensitive and linguistically appropriate assistance in selecting a plan and completing the enrollment/disenrollment form.

d) A county-specific list of important telephone numbers.

e) County-specific plan comparison chart(s) that illustrates the similarities and differences between dental plans.

f) A post card that the beneficiary may use to request a new informing packet in the event he/she wishes to obtain a packet in another language, change plans or disenroll.

g) A postage-paid envelope for the beneficiary's use in returning the enrollment/disenrollment form.

5) A Dental enrollment/disenrollment form.

6) Additional enrollment materials, as requested by the State.

b. The Contractor shall update, edit and translate existing informing and enrollment/disenrollment materials, as directed by the State. These materials include:

1) All letters, notifications and materials referenced in Enrollment/Disenrollment section.

2) Renotification letters and materials

3) Any other existing letters or documents determined by the State to be for the purpose of informing beneficiaries about the Medi-Cal Managed Care or Health Care Options programs.

c. The Contractor shall update and translate the script to be used by Contractor staff in making HCO presentations, as directed by the State.

d. The Contractor shall update and translate all other existing materials to be used during presentations, education and outreach sessions, or telephone calls. These materials include, but are not limited to; slide or video presentations, program posters, maps and/or directions to presentation sites, standardized responses to questions, and other materials to be presented to, or discussed with, beneficiaries.

e. All updated materials developed by the Contractor shall meet the standards specified in 3. below, and the general requirements outlined in 4. below.

2. New Materials

a. The Contractor shall develop new materials, as requested by the State, for the purpose of informing beneficiaries about the Medi-Cal Managed Care or Health Care Options programs.

b. The Contractor shall develop new materials, requested by the State, to be used during presentations, education and outreach

sessions, or telephone calls. These materials include, but are not limited to, such items as slides or video presentations, program posters, maps and/or directions to presentation sites, standardized responses to questions, and other materials to be presented to, or discussed with, beneficiaries.

c. Using the current HCO presentation script, the Contractor shall develop new audio-visual materials to enhance presentation of that script in a manner that ensures maximum beneficiary interest and participation in the HCO presentation.

d. The Contractor, as directed by the State, shall provide editing and translation services for any materials developed by the State for use in the HCO program.

e. All new materials developed by the Contractor shall meet the standards specified in 3. below, and the general requirements outlined in 4. below.

f. The Contractor shall be paid for new materials pursuant to Cost Reimbursement Categories (Subsection 8.7.1).

3. Standards for Materials

The Contractor shall meet the following standards when developing and producing all written materials:

a. The reading level of all written materials, scripts for presentations or audio-visual materials shall be equivalent to fourth grade or lower, as determined by a commonly accepted scoring mechanism such as Gunning-Fogg or the Fleisch readability index. A glossary shall be included when using terms that are more complex than sixth grade level as determined by the scoring mechanism or terms that are specific to providing managed care.

b. Materials shall be produced in English, and in all threshold languages as determined by the State.

c. Materials developed by the Contractor must be culturally and linguistically appropriate in order to assist beneficiaries in making an informed choice.

d. Materials shall be prepared and provided for the visually or hearing impaired, or other special needs audiences as requested by the State.

e. All materials shall be focus tested using a State-approved process, to ensure they are culturally and linguistically appropriate, and adequately meet the information needs of the beneficiary population. A State representative shall be present during the focus tests.

4. General Requirements for Materials Developed

a. The Contractor shall submit a schedule for development or update of State-requested materials no later than 10 business days after receipt of the State request. The schedule shall specify that submission of drafts for State review shall occur no later than 60 calendar days from the date the State requested development of the new or updated material. The Contractor shall obtain State approval of the schedule prior to development of the materials.

b. The State may require the Contractor to provide expedited development or updating of beneficiary letters specified in Materials Development (Section 3.3) and Production and Customer Assistance (Section 3.5) up to 12 times annually. Under these circumstances, the Contractor shall develop and/or update the letters, including translation, within five business days of receiving the State request. A letter, as used in this subsection, is defined as up to four sheets of paper, whether printed on one or both sides. The Contractor focus testing requirements will be waived for expedited developments.

c. All materials developed by the Contractor must present unbiased and culturally sensitive information to beneficiaries.

d. The Contractor shall obtain input, through the State, from DHS Medi-Cal Managed Care Advisory Group, as specified by the State, during the development process on all new materials and on all existing materials that the State determines are being substantially updated.

e. Concepts and materials developed for use in the enrollment or informing process are the property of the State, and the Contractor agrees to relinquish all rights to the materials.

3.3.2.2 Production of Materials

Production includes the preparation of camera-ready copy (including but not limited to image scanning and data processing support), printing and laser

letter set-up, printing or photocopying as appropriate, and delivery of produced materials to the mail operations site. The Contractor is responsible for production of all required materials as specified in this contract. This responsibility includes either producing the materials directly or arranging for their production through the use of sub-contractors.

1. The Contractor shall produce all letters, enrollment, informing and outreach materials for which they are responsible pursuant to the provisions in Development of Materials (Subsection 3.3.2.1).

2. The Contractor shall produce provider directories as specified in Development of Materials (Subsection 3.3.2.1). These directories include a list of primary care providers, by health plan, from which the beneficiary may select his/her primary care provider, as well as certain other providers. The health plans shall provide the camera-ready copy to the Contractor for set-up, printing and delivery to the mail operations site.

3. The Contractor shall produce some, if not all, provider directory periodic update inserts. The health plans shall provide camera-ready copy to the Contractor for set-up, printing and delivery to the mail operations site. The provider directory periodic update inserts include additions to, deletions from, or modifications of the list of primary care providers included in the provider directories.

4. The Contractor shall obtain State approval of all printed or audio-visual materials prior to production including, at a minimum, content, format, materials used, size, and method of reproduction (i.e. lithography, photocopy, etc.).

5. The Contractor shall submit a schedule for production of State-requested materials at the same time it submits those materials to the State for approval. The Contractor shall obtain State approval of the schedule prior to production of the materials.

6. Concepts and materials produced for use in the enrollment or informing process are the property of the State, and the Contractor agrees to relinquish all rights to the materials.

3.4 MAILING FUNCTIONS

3.4.1 OVERVIEW

The Contractor shall be responsible for all mailings to Medi-Cal beneficiaries regarding managed care enrollment information, options, notifications and changes. The Contractor shall conduct all mailings in a timely and uniform

manner in those counties that shall require an HCO program due to the presence of new or existing managed care plans operating in those counties, and in any future counties as designated by the State. The Contractor shall mail language- and county-appropriate information to Medi-Cal beneficiaries mandated to enroll in a Medi-Cal managed care plan, as well as to Medi-Cal beneficiaries who may enroll in a plan on a voluntary basis, and to others as designated by the State.

In addition, the Contractor shall be responsible for appropriate storage, effective and accurate inventory management, maintenance and tracking, disposition of returned and obsolete materials, and timely retrieval of all informing materials that are periodically mailed to beneficiaries as a part of the HCO program. For mailing purposes, the term "beneficiary" means either an individual beneficiary or the Medi-Cal head of household (case head). The State and the Contractor shall work cooperatively to ensure that the content of all mailings is accurate and consistent with the State's directions, and that the materials are mailed or delivered to beneficiaries, the State and others in a timely manner.

3.4.2 CONTRACTOR RESPONSIBILITIES

The Contractor shall employ staff of a sufficient number and with an appropriate level of expertise to oversee and facilitate all mailing functions. The Contractor shall be responsible for performance of these activities, whether they are carried out by Contractor staff or by subcontractors.

3.4.2.1 Mailing of informing packets

Informing packets shall include the items specified in Development of Materials (Subsection 3.3.2.1), as well as provider directories and Indian Health Clinic brochures. The Contractor shall prepare and mail the appropriate language-specific informing packets and letters to beneficiaries in designated counties who are eligible for enrollment in a health care plan and are listed on the various eligibility files provided by the State. The only exception to this requirement is that packets shall not be mailed to beneficiaries identified as homeless based upon specific county Post Office Box addresses on the various eligibility files.

1. Daily Mailings

   On a daily basis, the Contractor shall receive the Daily HCO File, listing two types of information. First, the file includes individuals who are assigned to mandatory aid codes in counties where managed care enrollment is required. Second, the file includes updated information on beneficiaries that may enable the Contractor to begin the enrollment process. The Contractor shall mail informing packets to those

beneficiaries listed on the Daily HCO File who are eligible to enroll in managed care in accordance with State guidelines. These packets shall be language-specific and shall include appropriate materials, by county, as specified in Materials Development and Production (Section 3.3). Packets shall be mailed within three business days of the date the beneficiary was submitted to the Contractor on the daily file, unless otherwise specified by the State.

2. Mailings Resulting from Reconciliation Process

The Contractor shall mail the appropriate informing packets to beneficiaries who are available for assignment because they are not in a health plan and are identified through the monthly reconciliation process between MEDS and the Contractor's system. Packets shall be mailed within three business days of the date following completion of the monthly reconciliation process.

3. Mailings in Response to Beneficiary Packet Requests

For informing packets requested by individual beneficiaries, the Contractor shall mail the appropriate informing packet to the beneficiary within three business days of the request.

4. Mass Mailings

The Contractor shall process mass mailings of informing packets or other materials upon request by the State. Mass mailings may result from a variety of activities including, but not limited to, county conversions, redeterminations, changes in plan options, or ZIP code carve-out changes. The Contractor shall work with the State to develop a county-specific schedule for the mass mailing to beneficiaries included in special files to be provided by the State or created by the Contractor, as directed by the State. The Contractor shall develop the schedule taking into consideration the size of population, the amount of incoming workload, and the size and number of managed care plans in the county. The Contractor shall submit the schedule to the State for approval no later than ten business days from the date the State notifies the Contractor of the need for a mass mailing. Once the schedule is approved by the State, the Contractor shall mail the informing packets to the scheduled beneficiaries in accordance with the State-approved schedule.

5. Mailings Due to Expiration of Medical and Non-medical Exemptions

For beneficiaries whose Medical or Non-medical exemption has expired, the Contractor shall mail a letter 45 days prior to expiration of

the exemption and the appropriate informing packet within five business days of the date of expiration of the exemption.

6. Packets to be Included in Over All Bid Price But Not Separately Reimbursed.

   The Department will not reimburse up to 175,000 per contract year.

   a. Upon request from a participating plan, the Contractor shall mail a complete copy of the applicable current, approved county informing packet, with the exception of the informing letter, to the plan within three business days of receipt of the request.

   b. For others identified by the State, the Contractor shall mail the requested informing packet to the requester within three business days of the date of the request, unless otherwise specified by the State.

   c. Training

   d. Outreach/Enrollment

3.4.2.2 Delivery/Shipping of Informing packets

The Contractor shall deliver or drop ship informing packets as described in this section.

1. In an exceptional circumstance the Contractor may be asked to deliver Informing packets, upon request, to the State Department of Health Services at any of its various Sacramento County locations, within the time frame specified by the State. In no event shall the Contractor be required to provide the packet in less than two hours.

2. The Contractor shall ensure that a sufficient number of county-appropriate, current informing packets are delivered to and available for use in the various presentation locations in advance of the presentations.

3. The Contractor shall deliver or ship multiple copies of informing packets to a participating managed care plan within five business days of receiving a request from the State to deliver such packets to the plan.

3.4.2.3 Other Informing material mailings

3.4.2.3.1 Annual Renotification mailings

The Contractor shall mail language-, county- and plan type (medical, dental, etc.)-appropriate annual renotification materials to all mandatory and non-mandatory Medi-Cal beneficiaries who have been continuously enrolled in the same health care plan for 12 consecutive months.

1. The Contractor shall identify these beneficiaries based upon enrollment data contained in the Contractor's HCO system.

2. The Contractor shall mail the language-, county-, plan type-appropriate annual renotification materials within ten business days of the beneficiary's 12-consecutive-month plan enrollment anniversary date. If more than one beneficiary in the Medi-Cal case unit has the same anniversary date for the same plan type, the Contractor shall mail only one set of annual renotification materials to that case unit.

   If the beneficiary is enrolled in more than one plan type (medical, dental, etc.) with a different anniversary date for each, the Contractor shall send the appropriate plan type annual renotification material for each plan type anniversary date.

3. The Contractor shall respond to beneficiary requests for informing packets that result from the annual renotification process in accordance with requirements in Contractor Responsibilities-Informing Beneficiaries (Subsection 3.6.2).

3.4.2.3.2 Mailing of Other Information/Materials

1. The Contractor shall provide enrollment/disenrollment forms, with envelopes, to the plans within five business days of receipt of the request from the State.

2. Within five days from receipt of information, contractor shall send approved informing notice and county-appropriate materials to current Managed Care enrollees whose aid code has changed from mandatory to voluntary to notify them of all available Medi-Cal options.

3. The Contractor shall be responsible for Ad Hoc mailings as specified by the State. These mailings may include, but are not limited to letters, post-cards, and fliers.

3.4.2.4 Mailing Standards

1. The envelopes in which the enrollment, renotification or other informing materials are mailed shall be of sufficient size and strength to accommodate the materials, in accordance with State specifications.

2. The materials sent to the beneficiaries shall be 99 percent accurate, based upon a comparison of the material contained in informing packets or renotification materials with material contained in the approved control binders. An average monthly accuracy rate and specific daily rate shall be determined. Results of daily sampling shall be available to the State within one business day of the date of the request. Results of all required sampling, including both daily and monthly rates, shall be provided to the State in the Monthly Progress Report (Subsection 3.10.5.23).

3. The Contractor shall utilize all postal incentives available when mailing materials to beneficiaries and others.

    a. Postal incentives that the Contractor shall utilize include, but are not limited to, ZIP+4 coding, bar-coding, First Class Five-Digit Presort, First Class Three-Digit Presort and any other class mail presorts. When available, the Contractor shall implement the eleven-digit Delivery Point Bar-coding when the United States Postal Service (USPS) publishes specifications and incentives. MEDS has space reserved for the complete USPS standardized address, including ZIP+4, ZIP delivery point DOE and ZIP check digit.

    b. The State is currently working to upgrade the manner in which MEDS handles addresses. The project is intended to allow beneficiary addresses to be matched against Coding Accuracy Support System (CASS)-certified software when a new address is received. MEDS also shall be capable of carrying three separate standardized addresses, residence address, mailing address and authorized representative address. One project objective is to standardize all addresses on MEDS, and then to standardize new addresses on a daily basis as MEDS transactions are processed. The Contractor shall accept and use the standardized address designated by the State. The State anticipates that this project shall be completed by the date of contract award.

    c. USPS letters and flat mailings to beneficiaries shall be bar-coded and presorted to take advantage of current and future postal incentive discounts that are, or may be, offered. The Contractor shall remain up-to-date on all USPS guidelines and

incentives and shall subscribe to the Domestic Mail Manual and Postal Bulletins.

d. During the contract period, the USPS may publish a variety of incentives that can reduce postal expenses. The Contractor shall diligently explore these incentives and shall implement those modifications that effect postal savings. The Contractor may claim a share of those savings under Terms and Conditions- Opportunities for Reduction in Operating Costs (Section 6.15), if the Contractor identifies and implements modifications beyond those called for by this contract.

3.4.2.5 Mailing Operations

1. The Contractor shall maintain informing packet control binders for each county included in the HCO Program. Each binder shall contain current enrollment materials, in all threshold languages, that have been approved by the State for inclusion in the informing packets. One set of binders for each county shall be maintained at each of the following locations: the State-specified site, the Contractor site, and the mail operations site(s). The mail operations supervisor shall use the binders to ensure that proper informing materials are included in each beneficiary informing packet. A control list of all current informing packet materials shall be kept in each binder. The Contractor shall update the material in all control binders within one business day following receipt of State-approved changes to that material. Binder updates shall be logged on a State-approved tracking form, which shall be kept at the front of each binder.

2. The Contractor shall maintain three sets of annual renotification control binders for each county included in the HCO Program. Each binder shall contain current annual renotification materials, in all threshold languages, that have been approved by the State. One set of binders for each county shall be maintained at each of the following locations: the State-specified site, the Contractor site, and the mail operations site(s). The mail operations supervisor shall use the binders to ensure that proper renotification materials are sent to beneficiaries. A control list of all current annual renotification materials shall be kept in each binder. The Contractor shall update the material in all control binders within one business day following receipt of State-approved changes to that material. Binder updates shall be logged on a State-approved tracking form, which shall be kept at the front of each binder.

3. The Contractor shall maintain three control binders for all other informing materials. Each binder shall contain current informing materials, in all threshold languages, that have been approved by the

State. One binder shall be maintained at each of the following locations: the State-specified site, the Contractor site, and the mail operations site. The mail operations supervisor shall use the binder to ensure that proper informing materials are sent to beneficiaries. A control list of all current informing materials shall be kept in each binder. The Contractor shall update the material in all control binders within one business day following receipt of State-approved changes to that material. Binder updates shall be logged on a State-approved tracking form, which shall be kept at the front of each binder.

4. The Contractor shall appropriately and accurately select materials for the fulfillment of informing packets, annual renotification packets, and other mailings of informing materials.

5. Enrollment and annual renotification packets should not be prepared by the mail operations staff more than five business days in advance of receiving a mail-out file.

6. For mass mailings in response to such activities as conversion or processing of redetermination files, or for other special mailings, the Contractor shall mail to the State and to the plans, for each affected county in which the plan operates, a sample copy of all materials mailed to the beneficiaries, prior to or simultaneously with the scheduled mailing(s), along with a letter identifying the approximate number of packets mailed out, by county.

7. The Contractor shall receive, identify and route to the appropriate State location, as specified by the State, all documents, returned Temporary Assistance for Needy Families (TANF) checks or other items not related to the HCO program but included in incoming mail.

8. The Contractor shall develop and implement an automated process for tracking and reporting its success in meeting all required time frames specified in Mailing Functions.

3.4.2.6 Processing Returned Mail and Address Changes

1. The Contractor shall receive and process all undelivered informing packets. Within two business days of receipt, the Contractor shall update the HCO system to indicate that the informing packet sent to a specific beneficiary was returned undelivered, remove the beneficiary from the default path, and remove and confidentially destroy any material containing beneficiary-specific information. Within ten business days of receipt, the Contractor shall disassemble the undelivered informing packet, return reusable materials to inventory and recycle/destroy non-reusable materials, and appropriately update

inventory control information to reflect the return to stock of reusable materials. Reusable material is defined as material that is still valid and is cost effective to re-stock.

2. If the informing packet is returned to the HCO Contractor, the beneficiary's file shall be flagged to indicate that the packet was not delivered, and no further mailings or assignment process activity shall be conducted relative to that beneficiary until the Contractor researches new address information from MEDS. The Contractor shall return the beneficiary to the notification and assignment process within three business days of receiving a new address notification through the Daily HCO File or the monthly reconciliation process, whichever is sooner.

3. The Contractor shall receive and process all undelivered annual renotification materials. Within two business days of receipt, the Contractor shall update the HCO system to indicate that the renotification materials sent to a specific beneficiary was returned undelivered and remove and confidentially destroy any material containing beneficiary specific information. Within ten business days of receipt, return reusable materials to inventory and recycle/destroy non-reusable materials, and appropriately update inventory control information to reflect the return to stock of reusable materials. Reusable material is defined as material that is still valid and is cost effective to re-stock.

4. Based upon undelivered informing packet or renotification material address information, the Contractor shall compile and send to the affected counties on a monthly basis a list of bad addresses, sorted by eligibility worker, if available. Each monthly list shall be cumulative, including all bad addresses for which no new address has yet been provided via MEDS. The Contractor shall send this list to the State and the affected counties no later than the fifteenth calendar day of the month following the month for which the data has been compiled. This report may be supplied in an automated electronic format if agreed to by the County and/or State.

5. Upon receipt of a corrected address from any source other than MEDS, the Contractor shall compile monthly and send to the affected counties a list of corrected addresses, sorted by eligibility worker, if available. Each monthly list shall be cumulative and shall include all corrected addresses for which no new address has yet been provided via MEDS. The Contractor shall send this list to the State and the affected counties no later than the fifteenth calendar day of the month following the month for which the data has been compiled.

6. The Contractor shall work with the U. S. Postal Service to ensure that the Contractor is notified of a beneficiary's new address in the event that the Postal Service provides the forwarding address. Information received by the Contractor in this manner shall be included in the list specified in 5 above.

3.4.2.7 Stock On Hand

The Contractor shall maintain sufficient enrollment, informing and other HCO materials to meet contract requirements for timely mailing and delivery of all such materials. The Contractor shall be responsible for the storage and stocking of all materials.

1. Location of Materials

   The Contractor shall stock all enrollment, informing, and other HCO materials for which it has mailing or delivery responsibility at a single central warehouse location within a 30 mile radius (as determined by freeway access) of the State Capitol building in Sacramento.

2. Inventory Control Methods

   a. The Contractor shall maintain inventory control of materials to be mailed or delivered by the Contractor at all times.

   b. To ensure that sufficient, appropriate HCO materials are available to meet the contract requirements, the Contractor shall develop and maintain an inventory system. This system shall, at a minimum, accurately account for every item of inventory at all times; generate reports that accurately reflect inventory on hand for each inventory item; project upcoming inventory need; and track and identify the inventory re-order point for each inventory item.

   c. The HCO Inventory system error rate shall be no greater than 5% per item.

   d. Any data on the volume of specific items maintained in the inventory system shall be provided to the State within one business day of receiving a request, either via hard copy or through State on-line system access at a State-designated site, and shall be verifiable through State monitoring.

3. Replenishment of Stock

   a. Contractor-Produced Materials

The Contractor shall arrange for timely production of all Contractor-produced materials to ensure that the Contractor is able to meet contract requirements at all times. See Production of Materials (Subsection 3.3.2.2) for a description of materials that must be produced by the Contractor.

b. Provider Directories

Provider directories may be Contractor-produced, plan-produced, or State-produced. The Contractor shall include in the informing packet the latest approved provider directories in stock for the appropriate county, as indicated by the county code on the beneficiary record. The Contractor shall maintain a sufficient stock of provider directories for this purpose at all times, in accordance with the following provisions.

1) Contractor-Produced Directories

In order to ensure appropriate stocking of Contractor-produced county-specific, plan-specific directories, the Contractor shall produce any provider directory not provided by the state or the Plan(s) and produce the required provider directories in accordance with the provider directory replacement process and schedule established by the State.

2) Plan- or State-Produced Directories

State policy allows the Plans to replace current versions of directories on a quarterly basis.

a) The Contractor shall notify the State in writing when the inventory of any provider directory reaches a minimum 45-business-day supply. The notice must include a description of the directory needed, inventory on hand, estimated daily usage, and the number needed for a 90-business-day supply.

b) Directories shall be delivered to the Contractor's designated location by the plan or the State at least five business days prior to the inventory re-stock requirement date.

c) If the Contractor gives the State timely written notification of the need for plan- or State-produced directories and the plan or the State fails to deliver the directories on a timely basis, thus causing the Contractor to run out of necessary inventory, the Contractor shall not be responsible for meeting State timeliness requirements until five business days after the requested inventory order arrives.

c. Provider Directory Inserts

The Contractor shall maintain an appropriate stock of provider directory inserts for inclusion in provider directories mailed out in informing packets in accordance with the State replacement process and schedule.

d. Other State-Produced Materials

For all other HCO materials produced and provided to the Contractor by the State, the Contractor shall follow the procedures specified in b above.

e. Indian Health Clinic Materials

Indian Health Clinic materials shall be include in specific county informing packets as directed by the State. Indian Health Clinic materials shall be provided to the Contractor by the State. The Contractor shall notify the State in writing when the inventory of one or more of the specific Indian Health Clinic materials reaches a minimum 45-business day supply. The notice must include a description of the material needed, inventory on hand, estimated daily usage, and the number needed for a 90-business day supply. The materials shall be delivered to the Contractor's designated location by the State at least five business days prior to the inventory re-stock requirement date. Beneficiary mailings shall not be held if there is insufficient Indian Health Clinic materials available.

4. Obsolete Materials

Within ten business days of receipt of written notification from the State, specified obsolete materials shall be removed from inventory, and the inventory information or data system shall be updated to reflect this removal. The materials shall then be recycled or destroyed or returned to the plan in accordance with State requirements.

3.5 CUSTOMER ASSISTANCE

3.5.1 OVERVIEW

The Contractor must provide assistance to beneficiaries in understanding, selecting, and using managed care plans, and must assure that this assistance is readily accessible to both beneficiaries and their authorized representatives. This assistance shall emphasize beneficiary rights and responsibilities, including annual renotification, as managed care plan enrollees.

An important goal of the HCO Program is to provide every Medi-Cal applicant/beneficiary, who shall be required or is eligible to enroll in a health or dental plan under the Medi-Cal managed care program, with the opportunity to attend a presentation describing that individual's rights and enrollment choices. The primary objective of the HCO presentation is to educate beneficiaries to make an informed plan choice. An effective education program ultimately increases the number of potential eligible enrollees who choose a plan prior to or during the informing process, thereby avoiding default or assignment to a plan. The Contractor may use Contractor staff to conduct the presentations, or it may subcontract with county welfare departments or community-based organizations to conduct and provide space for the presentations. However, the Contractor shall be responsible for the quality, accuracy and timeliness of the presentations, and for ensuring that they are conducted in a manner that resonates with beneficiaries, with a goal aimed at maximizing beneficiaries' choice rates.

Past experience has demonstrated that beneficiaries who attend presentations as part of the eligibility determination process, or soon thereafter, make a choice of health plan more frequently that those who do not. For this reason, the Contractor is encouraged to work directly with county welfare departments to ensure that presentations can be conducted in close proximity to the locations of the face-to-face Medi-Cal eligibility interviews.

If an individual applies for Medi-Cal at a county welfare department facility where HCO presentations are conducted on site, the eligibility worker has been requested to refer that individual to the presentation. If no HCO presentation is offered at the county welfare department on the date an individual applies for Medi-Cal, or if the individual does not attend a presentation, or does not make a choice at the time of the presentation, that individual shall be sent an informing packet when they are determined eligible. This informing packet shall contain a presentation schedule.

The Contractor shall also be responsible for maintaining a Telephone Service Center to provide customer assistance. Telephone calls must be of sufficient

length to assure that adequate information is gained from and/or imparted to the caller. The Telephone Service Center must be able to respond to callers in all threshold languages and through Teletype (TTY) devices for the hearing-impaired at the time the beneficiary places the call, during regular business hours. During non-business hours, the Contractor must provide the capability for callers to leave a voice message and ensure that a Customer Services Representative (CSR) returns the call within one business day. Calls that are not resolved by the Telephone Service Center staff on the date the call is received shall be referred to the Research Unit, which shall be responsible for investigating and responding to written correspondence and to inquiries referred from CSRs.

3.5.2 CONTRACTOR RESPONSIBILITIES – PRESENTATIONS

3.5.2.1 Administrative Support of HCO Presentations

The Contractor shall make all arrangements necessary to conduct HCO presentations. These arrangements shall include, but shall not be limited to the following.

1. Presentation Sites

   The goal of the presentation site selection process is to identify and secure sites that ensure the highest attendance rates for all cultural and linguistic groups of Medi-Cal beneficiaries. During Takeover, the Contractor shall develop a space and facilities plan specifically designed to meet this goal. During Operations, the Contractor shall continue to maintain and update the plan, adding or deleting sites as appropriate to ensure that this goal is achieved. The Contractor is encouraged to hold presentations at county welfare intake offices wherever possible.

   a. The Contractor shall maintain and update the space and facilities plan submitted during Takeover that provides for group HCO presentations in county facilities and/or other approved public or nonpublic facilities. The Contractor shall reach out to and work with advocacy groups, community-based organizations and county welfare departments to determine appropriate presentation sites on an ongoing basis. All proposed changes to the plan shall:

      1) Identify new presentation sites or sites to be deleted.

      2) Provide a narrative justification of the proposed change to the plan.

3) Provide an analysis of the cost effectiveness of the new site or the deletion.

4) Specify the number of staff who shall conduct presentations at each new site, hours of coverage, and language represented.

5) For a new site, provide either evidence that space has been obtained or an approach and time frame for obtaining the space.

6) The Contractor should obtain a Memorandum of Understanding (MOU) for each facility to be used as a presentation site. The MOU shall include arrangements for any equipment deemed necessary for the Enrolment Service Representatives (ESR) to perform site presentations.

b. The Contractor shall consider space and geographic limitations, including convenience of the site to beneficiaries in terms of transportation and parking, in determining the most cost-effective methods to provide presentations to the maximum number of beneficiaries.

c. For new presentation sites, the Contractor shall conduct a site evaluation prior to requesting State approval as a new presentation site. The Contractor shall submit the written request for site approval to the State thirty calendar days prior to their proposed use or unless otherwise agreed upon. A report on the appropriateness of the proposed site shall be submitted with the request for State approval.

d. On an ongoing basis, the Contractor shall provide or arrange to obtain appropriate furniture, equipment, office supplies, outlets and electronic communication devices where HCO presentations may occur. These include, but are not limited to, telephones, facsimile equipment, and computer modems for use by Contractor personnel, in county facilities or other approved public or nonpublic facilities where HCO presentations shall occur. Space size and availability may vary at county sites where presentations shall occur.

2. Scheduling

The Contractor shall schedule group or individual HCO presentations at regular intervals and at various locations within a county to ensure

that presentations are available to applicants and beneficiaries during the HCO informing process.

a. On a monthly basis, the Contractor shall submit to the State its proposed HCO presentation schedule for the following two months and shall specify the Contractor's proposed Enrollment Services Representative (ESR) Full Time Employee (FTE) level, by site, for that schedule. The schedule shall be submitted no later than the tenth calendar day of the month preceding the months for which the schedule is provided (e.g., January 10 for the February/March schedule), and must be approved by the State prior to its implementation. The schedule for a specific site shall be available at the site no later than the first day of the first month covered by the schedule.

b. The Contractor shall create and maintain presentation schedules in binders located at a State site specified by the State. The Contractor shall update the binder at that State site within three State business days of receipt of the most current approved and printed presentation schedule.

c. The Contractor shall mail State-approved presentation schedules to presentation sites, health plans, advocate groups and community-based organizations on a monthly basis, as specified by the State.

d. All scheduled presentations shall be conducted. The Contractor shall not revise the presentation schedules without prior approval from the State. The Contractor shall develop a plan for back-up coverage to address staff absence, as well as increased enrollment activity, and shall ensure that back-up personnel are provided so there is no disruption in HCO presentations. If the State approves a request to alter the presentation schedule, the Contractor shall so inform its Call Center staff within one hour of receipt of the State's approval, and update the schedule binders discussed in b. above within one State business day. In addition Site Administration (i.e. county welfare department) should be notified of the change.

e. If any scheduled presentation fails to take place, the Contractor shall so notify the State by telephone within one hour of the time the Contractor learns that the presentation did not or will not take place. The Contractor shall inform the State of this failure in writing within three business days of the telephone notification, and shall include a corrective action plan.

3. Materials

   a. In cooperation with the State and counties in which presentations are conducted, the Contractor shall develop necessary procedures and forms for county welfare departments to use in referring applicants and beneficiaries to HCO presentations such as easily understood maps and/or printed directions to presentation sites.

   b. The Contractor shall furnish all necessary resources for effective presentations, including but not limited to supplies, audio-visual equipment and visual aids.

   c. The Contractor shall ensure that the most current State-approved informing packets and other appropriate materials are available for distribution and, if applicable, posted at each HCO presentation site, in accordance with State requirements. To accomplish this, materials shall be distributed to the appropriate sites within ten business days of the date the Contractor receives the approved printed material.

   d. The Contractor shall submit to the State for review and approval all proposed procedures, written materials and forms used for HCO referrals and presentations. These materials shall be submitted at least sixty calendar days prior to their proposed implementation and distribution, unless otherwise directed by the State.

4. Presentation Monitoring

   a. The Contractor shall use a beneficiary feedback evaluation form to assess applicant/beneficiary satisfaction with each HCO presentation. The Contractor shall make these forms available at each presentation site to enable beneficiaries and other attendees to evaluate the presentation in a confidential manner. The Contractor shall maintain copies of completed beneficiary/attendee evaluation and/or critique forms for six months, filed by county, by presentation site, and by date. The Contractor shall retain these copies at its central Sacramento location.

   b. The Contractor's ESR Supervisor(s) shall use ESR Observation/Evaluation Forms to monitor and evaluate one presentation per ESR at least once per month. Evaluations shall include, but are not limited to, knowledge and skills, content and delivery of the presentation, availability and

accessibility of the ESR, and knowledge of Health Care Options. If the Contractor's ESR Supervisor observes a problem with a specific ESR, the supervisor shall monitor the ESR's presentations no less often than weekly until corrective action has been taken and the problem has been resolved. The Contractor shall maintain copies of the completed ESR Observation/Evaluation Forms for six months, filed by ESR and by month. The Contractor shall retain these forms at its central Sacramento location.

c. Any Contractor-proposed modifications to the presentation evaluation/critique instrument(s) developed during Takeover shall be approved by the State prior to implementation of the modifications.

d. The Contractor's ESR Supervisor(s) shall monitor and evaluate the effectiveness of each presentation site on a quarterly basis and shall include a report on each site monitored in the next Monthly Progress Report.

e. The Contractor shall recommend to the State site closures if a site is determined by the Contractor to be underutilized. Upon State approval of a recommended site closure, the closure shall be reflected in the monthly presentation schedule submitted in accordance with Administration Support of HCO Operations (Subsection 3.5.2.1). In addition, at the State's request, the Contractor shall discontinue using specified sites.

f. All presentations shall be open to authorized Federal, State, and County personnel. State staff shall audit presentations and presentation sites, with or without prior notification to the Contractor, and shall notify the Contractor of any deficiencies. Within ten business days of receipt of this notification, the Contractor shall demonstrate that reported deficiencies have been corrected or submit a corrective action plan to the State.

5. Staffing

a. Qualifications

ESRs assigned to conduct presentations shall, at a minimum:

1) Speak, read, and write English in an understandable manner.

2) Have presentation and/or public speaking experience (with marketing or public relations experience desirable).

3) Have experience in working with low-income populations.

4) Speak, read and write in any threshold language at a level understandable by the beneficiary for which they are providing service.

5) Present required information and materials in a culturally and linguistically competent, imaginative and interactive manner that resonates with beneficiaries.

b. Staffing Levels

The number of ESRs shall range between 70 and 130 staff members within the bid rates of this contract. 100 staff are being used as the basis of this bid. However, the actual number of staff for start-up shall be defined by the State two months after the contract effective date, including the percentage of bilingual ESR's, by threshold language. During the life of the contract, with the assistance of the Contractor, the State shall determine and authorize the maximum number of ESR Full Time Employees by county. This may be adjusted throughout the term of the contract based on the State's assessment of need. Elements used to determine this need shall include number and location of presentation sites, number of potential beneficiaries attending presentations, materials used for presentations, and length of presentation. The State shall provide forty-five calendar days notice to request a decrease in the number of ESRs in a county and up to sixty calendar days notice to increase the maximum number of ESRs in a county.

c. Supervision

The ESR Supervisor to full-time ESR ratio shall be no less than 1:8 (eight ESRS per one ESR supervisor). The Contractor shall employ one Regional Manager in Northern California and one Regional Manager in Southern California.

d. ESR Administrative Support

The Contractor shall provide a regional headquarters facility (home office) in both Southern California and Northern California, which shall serve as a base for ESRs working in the

region. The Contractor shall provide sufficient supplies and equipment to support all ESR functions.

e. Prohibition on Other Duties

ESRs and ESR Supervisors may not be used to perform any other contractually required work, provide any other contractually required services or work to bring the Contractor into compliance with existing requirements, except those outlined in Contractor Responsibilities – Presentation (Subsection 3.5.2) and Contractor Responsibilities – Outreach and Enrollment Activities (Subsection 3.5.3), unless specifically authorized in writing by the Contracting Officer.

3.5.2.2 Conducting HCO Presentations

1. The Contractor shall make presentations to applicants and beneficiaries in the mandatory aid codes, as well as those in voluntary aid codes, which wish to attend. The Contractor shall adapt the presentations to each county welfare department's intake application process, and to the redetermination process in counties where fee-for-service is an option. Contractor staff shall provide presentations in a manner that accommodates county intake schedules, policies and procedures, and/or arrangements agreed to between the Contractor and the county.

   The Contractor is required to conduct presentations in all Two-Plan Model, Geographic Managed Care (GMC) and voluntary enrollment counties, as specified by the State.

   The current HCO contract requires that presentations be made in up to twelve Two-Plan Model counties, one GMC county and five voluntary counties. While there are now twelve Two-Plan Model counties and two GMC counties, the State anticipates that counties will contract directly with the State in a few cases to conduct presentations. Therefore, during the course of the contract, the Contractor must be prepared to make presentations in up to 13 mandatory counties, plus up to five voluntary counties.

2. The Contractor shall provide presentations according to the State's specifications, using only scripts approved by the State. The HCO presentation shall include, but shall not be limited to:

   a. Information designed to help beneficiaries/applicants understand how to complete an enrollment form and to assist beneficiaries/applicants with completion of an enrollment form.

b. Alternatives for beneficiaries/applicants to receive Medi-Cal benefits, with an emphasis on the managed care method.

c. A description of the services covered under the Medi-Cal program.

d. A description of all available managed care plans in areas where beneficiaries/applicants reside, and the area, by zip code, each plan serves.

e. A description of the beneficiary's enrollment/ disenrollment rights.

f. Information in response to managed care plan-related questions that arise during the HCO presentation from beneficiaries/applicants.

3. The Contractor shall document and report the attendance of all applicants and beneficiaries at the HCO presentation. The State, with assistance from the Contractor, shall specify the elements to be collected and reported.

4. The Contractor, as directed by the State, shall provide at a minimum, linguistic services to a population group of mandatory Medi-Cal beneficiaries residing in the proposed service area who indicate their primary language as other than English and whose language is a threshold language, i.e., and that meet either:

   - a numeric threshold of 3,000, or

   - concentration standards of either 1,000 in a single zip code or 1,500 in two contiguous zip codes.

5. The Contractor shall provide translation services and/or other assistance in understanding the presentation for hearing-impaired and/or sight-impaired individuals at selected presentation sites where beneficiaries request such assistance at least one business day in advance.

6. The Contractor shall ensure non-English, limited-English proficient, hearing-impaired, or sight-impaired applicants and beneficiaries who attend presentations understand their options and rights. Measures that will be taken shall include, but not be limited to:

a. Hiring or contracting with staff who can meet the linguistic needs of these individuals. Actions the Contractor shall take to ensure availability of appropriate staff include, at a minimum:

1) Assess, identify, and make available to the State upon request the linguistic capability of interpreters or bilingual employed or contracted staff.

2) Employ or contract with individuals bilingual in English and another threshold language to ensure that the linguistic needs of applicants and beneficiaries, as well as the requirements above, are met. Every threshold language shall be covered under this requirement.

3) Employ personnel with knowledge of the ethnic, cultural, social, and economic compositions of each county's beneficiary population. The Data Library includes a table, "Ethnic Grouping of Eligible Beneficiaries By County," that provides relevant information.

4) Consider employing or contracting with qualified, former AFDC/TANF recipients or Medi-Cal beneficiaries, individuals who possess Medi-Cal eligibility background/experience, and community-based organizations.

b. Provide written materials, enrollment/disenrollment forms, and/or media (e.g., videos/tapes) in threshold languages to assist non- and limited-English proficient beneficiaries.

7. The Contractor may be instructed to alter HCO presentation scripts periodically, but no more than three times annually, by county. If the State requests a change to a script, the Contractor shall make the required modifications and submit the modified script to the State no later than seven business days from the date of the State request, or as otherwise instructed by the State. Note: the focused testing requirements for this task will be waived.

8. The Contractor shall assign personnel to conduct HCO presentations at each site in order to inform beneficiaries/applicants of their options for receiving Medi-Cal benefits using State-approved scripts and materials.

9. The Contractor shall consistently and effectively conduct HCO presentations in a culturally and linguistically competent, imaginative

and interactive manner that resonates with beneficiaries. This shall include, but is not limited to:

a. Following the HCO scripts.

b. Using electronic audio and visual communication media such as videos, overheads, computer presentations, tape recordings, etc.

c. Employing other enhancements to the HCO presentation.

d. Ensuring that presenters are knowledgeable about Medi-Cal and managed care, and present required material in a dynamic fashion.

10. Enrollment/disenrollment forms completed and signed by applicants and beneficiaries shall be collected, forwarded for processing, and filed appropriately in accordance with Enrollment/Diserollment (Section 3.5).

3.5.3 CONTRACTOR RESPONSIBILITIES – OUTREACH AND ENROLLMENT ASSISTANCE

The Contractor shall be responsible for the following outreach and enrollment assistance activities:

1. On a monthly basis, the Contractor shall identify and submit to the State for approval, twenty calendar days in advance, unless under special circumstances, locations for outreach and enrollment assistance sessions, such as community centers, community meetings, health fairs, Women, Infants and Children (WIC) nutrition sites, churches, festivals and community-based organizations. Further, the Contractor shall schedule the sessions during normal business hours, 8 a.m. to 5 p.m., Monday through Friday, and outside normal business hours, as approved by the State. At the State's direction, the Contractor shall attend special events or forums identified by the State.

2. For special outreach sessions, the Contractor shall submit to the State for prior approval, a schedule of all outreach sessions. This schedule shall be submitted on the tenth calendar day of the month preceding the proposed outreach sessions, unless special circumstances prevent such advance notice. At a minimum, this schedule shall include:

   a. The name of the ESR or other Contractor representative conducting the session.

b. The organization or event served by the session, as well as the location.

c. Date and time of the session.

d. Anticipated number of beneficiaries attending.

3. The Contractor shall develop and implement written procedures for researching county MEDS input conflicts and communicating the results of the research to the appropriate county staff for correction. The Contractor shall provide the written results to the State within two business days of that communication.

4. The Contractor shall prepare an interview guide for use by ESRs and other Contractor representatives conducting outreach and enrollment assistance sessions. The interview guide, which shall be submitted to the State for approval prior to its use, shall cover, at a minimum, the following topics:

a. Description of services covered by the Medi-Cal program.

b. Importance of prompt selection of a plan and a primary care provider or clinic.

c. Requirement to select a plan, if the beneficiary is in a mandatory aid code.

d. Explanation of the consequences of failure to select a plan in a timely manner.

e. How to access care through a plan, including prenatal care, specialty care, referrals, and self-referral services (including the right to self-refer for family planning).

f. How to access services not covered by the plan (such as mental health, substance abuse treatment and dental services).

g. The importance of receiving preventive health care and Child Health and Disability Program (CHDP) services.

h. Questions about current health care providers and needs, in order to provide information that may assist the beneficiary in making an informed choice. These questions may include:

1) Do you have a doctor or clinic and, if so, do you wish to continue using this doctor or clinic?

2) Do you use specialists or do you want your children to see a pediatrician?

3) Do you have a preferred hospital?

4) Do you have any special health care needs?

5) Would you prefer to go to a doctor that speaks your primary language?

3.5.4 CONTRACTOR RESPONSIBILITIES – TELEPHONE ASSISTANCE

3.5.4.1 Telephone Service

1. The Contractor shall assist beneficiaries or their authorized representatives in understanding, selecting, and using their health care plan membership. In addition, the Contractor shall assist providers, health plans, counties or other interested parties who request, by telephone, information on the Program. In accordance with Security and Confidentiality (Section 3.8), the Contractor shall comply with State and Federal laws and regulations pertaining to confidential information and provide access to beneficiary-identifying information only to those persons or agencies who require the information in order to perform their duties in accordance with the contract.

2. Telephone assistance means: answering incoming calls; making outbound calls to return voice messages received after regular business hours within one business day of receipt; and making outbound calls to follow up on beneficiary issues that could not be completed during the initial incoming telephone call. Assistance shall include the following activities:

   a. Explaining how health care plans operate and how to use the resources of the plans.

   b. Explaining how to complete an enrollment/disenrollment form.

   c. Explaining health plan options in detail to enable potential beneficiaries to select a health plan/PCP. This includes determining the beneficiary's present health care provider and

assisting in determining which health plan(s) would permit the beneficiary to remain with their existing provider(s).

d. Explaining to beneficiaries in mandatory aid codes in fully operational mandatory managed care counties that if they do not select a health plan/PCP, one will be selected for them through the use of the automatic assignment process.

e. Explaining to beneficiaries who are potential managed care enrollees how to access care through the health plan, including specialty care, self-referral services, etc.

f. Providing information on alternatives to plan enrollment.

g. Explaining to existing plan members about the annual renotification process.

h. Verifying information through the State's MEDS file to confirm that the beneficiary is eligible to enroll.

i. Assisting beneficiaries in completing enrollment/disenrollment forms and changing enrollment from one health plan to another, or selecting fee-for-service if permitted.

j. Providing county-specific information, as directed by the State.

k. Providing information, as supplied through the State by health care plans, to beneficiaries on public transportation available to and from health care plan service sites.

3. The Contractor shall assist beneficiaries who request assistance, by telephone, in resolving problems associated with mandatory or voluntary participation in the HCO Program. Telephone assistance shall be provided by CSRs and shall consist of the following functions:

a. If the problem is associated with enrollment or disenrollment, the CSR shall use available resources such as the HCO system, MEDS, enrollment control binders, and procedure manuals to resolve the beneficiary's issue or problem. The CSR may place calls to health plans or the county in order to assist the beneficiary in enrolling in or disenrolling from a health plan. If the CSR cannot resolve the problem during the initial call or the same business day, then that CSR shall refer the beneficiary to the Contractor's Research Unit to resolve the problem through the procedures for processing enrollments and disenrollments as specified in Enrollment and Disenrollment.

b. If the problem is associated with eligibility, the CSR shall refer the beneficiary to the appropriate County Welfare Department office.

c. If the problem is associated with use of a health plan, the CSR shall refer the beneficiary to the plan in which the beneficiary is a member. The CSR shall ensure that beneficiaries who have a problem or grievance with their health plan are informed of their right to request a fair hearing. If the beneficiary requests information about the fair hearing process, the CSR shall refer the beneficiary to the Department of Social Services, as directed by the State.

d. If the beneficiary has already contacted the health plan and the problem has not been resolved to the beneficiary's satisfaction, the CSR shall refer the beneficiary to the State's Medi-Cal Managed Care Ombudsman.

1) The CSR shall advise the beneficiary that he/she can expect to receive a call or an answer from the Ombudsman within one business day following the date the Contractor notifies the Ombudsman of the problem.

2) When a referral is made to the Ombudsman, the Contractor shall, within one business day, forward (fax) an incident report to the Ombudsman.

3) The Contractor shall keep copies of all incident reports and make the reports available to the State, upon request.

4) The Contractor shall review incident reports on a monthly basis and categorize, summarize, and trend problem(s). If the problem is a systems and/or operational issue, the Contractor shall issue a problem statement.

5) The Contractor shall provide translation services and communication links between the beneficiary and the Ombudsman Unit, as requested by the State.

4. All other inquiries that cannot be resolved by the Telephone Service Center CSRs shall be referred to the Contractor's Research Unit. Examples of such inquiries include, but are not limited to, accessing enrollment/disenrollment forms or responding to correspondence.

3.5.4.2 Telephone System

1. The Contractor shall staff and maintain a telephone system with 65 to 105 toll-free lines to handle incoming and outbound call volume between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday (excluding holidays), Pacific Time. After regular business hours, the Contractor shall maintain an automated message system with the capability to collect caller information via voice mail. The State may authorize a reduction or increase in the number of toll-free lines if experience indicates such a reduction or increase is appropriate. The rights to use the sequential combinations of numbers that make up the toll-free numbers shall become/remain property of the State.

2. The Contractor shall notify a State-designated representative of any incident of Telephone Service Center downtime during regular or after business hours, within one business hour of the incident. Daily, Weekly, and Monthly Status Reports shall also include the date, time, number of minutes of duration, cause, and resolution of each downtime incident.

3. In order to support the Telephone Service Center, the State shall make MEDS available. The Contractor shall maintain an enrollment system that is available on-line during the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday (excluding holidays), Pacific Time. Unscheduled system downtime shall not exceed one-half hour per week on average per month. The system shall provide CSRs with access to beneficiary information including, but not limited to, the following:

    a. Mailing address;
    b. Status of beneficiary enrollment;
    c. Primary care physician of record;
    d. Medical exemptions and time of exemption; and
    e. Enrollment/disenrollment history.

3.5.4.3 Telephone Service Staffing

1. The Contractor shall employ a Customer Services Representatives Group (CSRG) to respond promptly by telephone to inquiries from beneficiaries, health plans, counties and other interested parties. The Contractor shall provide an organizational structure of operators, administrative staff, and management that consists of:

a. A CSRG staff at the ratio of three CSRs for every four toll-free lines;

b. A single liaison to the State and a CSRG manager to participate in meetings;

c. A CSRG manager and separate supervisory staff for the Telephone Service Center CSRs at the supervisor-to-operator ratio of 1:8 (eight operators per supervisor);

d. Clerical support staff including word processing; and

e. All other office and administrative support staff required to perform the functions.

2. The CSRG organization shall be structured to facilitate elevated levels of response and elevated levels of staff experience for possible career advancement. This organization also shall be structured so the Contractor's most knowledgeable staff is utilized before the Contractor refers a question or issue to the State. Minimum requirements for CSRG staffing shall include:

   a. An entry level classification, requiring the equivalent of high school completion; the ability to speak, read and write English; the ability to speak, read and write in any threshold language for which the incumbent is providing service; and prior work experience dealing with the public and low-income populations.

   b. A second level classification, requiring the equivalent of high school completion; the ability to speak, read and write English; the ability to speak, read and write in any threshold language for which the incumbent is providing service; knowledge of Medi-Cal and managed care; and at least two years of previous employment including significant telephone assistance experience.

   c. A supervisory level classification requiring significant knowledge of Medi-Cal and managed care and at least three years of experience in the CSRG or two years of experience supervising staff performing duties similar to the customer assistance activities described in this section.

3. The Contractor shall provide translation for each threshold language as well as English to English or Spanish to Spanish Teletype (TTY) services for incoming and outbound calls. Historical call volume by threshold language can be found in the Data Library.

a. Two months after the contract effective date, the State shall specify the number of bilingual operators required for each threshold language. The Contractor shall employ or contract with individuals bilingual in English and another threshold language to ensure that the linguistic needs of beneficiaries, as well as the requirements above are met.

b. For some threshold languages, it may not be cost-effective to staff the Telephone Service Center with bilingual CSRs skilled in those languages. Therefore, the State shall specify the threshold language(s) for which the Contractor may acquire third-party, real-time translation services (e.g., AT&T translation services). The State shall reimburse the Contractor for the additional cost for providing third-party translation services.

4. The CSRG staffing shall range between 20 and 80 staff members within the bid rates of this contract. 50 staff members are being used as the basis of this bid. However, the actual number of staff for start-up shall be defined by the State two months after the contract effective date, including the percentage of bilingual CSRs, by threshold language. During the life of the contract, the State may vary this number within these ranges at the same bid rate with a 30-day notice. The State fully expects to stay within these ranges. The State retains the right to negotiate a decrease in the size of the CSRG below 50, should experience demonstrate that Telephone Service Center activities could be accomplished successfully with fewer than 50 staff members. In the event the size of the CSRG either increases or decreases, the State shall provide 30 days notice to the Contractor. If workload requires more personnel than is available through the CSRG, the State may use the Change Order process to accomplish the work.

5. CSR staffing and CSR Supervisors may not be used to perform any other contractually required work, provide any other contractually required services or work to bring the Contractor into compliance with existing requirements, except those outlined in Contractor Responsibilities – Telephone Assistance, unless specifically authorized in writing by the Contracting Officer. This specifically authorized work cannot be billed to the CSRG.

6. The Contractor shall develop and maintain a recruitment and training plan that includes a training program for the CSRG, as defined in Training.

7. The Contractor shall maintain timely and accurate informing packet control binders, procedures manuals, computer resources and other

tools necessary to support the CSRG. Procedures shall be in place to immediately notify CSRs of all changes to policies and/or procedures or other pertinent information. Copies of notices shall be placed in a binder located on site and an additional copy shall be forwarded to the State for review within one business day of their distribution to Contractor staff.

3.5.5 CONTRACTOR RESPONSIBILITIES – RESEARCH UNIT

1. The Contractor shall employ a Research Unit to investigate and respond to correspondence regarding the HCO Program or to inquiries referred from the CSRG.

2. The Research Unit shall assist beneficiaries who request assistance by fax, in writing, or in person, or who have been referred by the CSRG, in resolving problems associated with mandatory or voluntary participation in the Program. These requests will include questions concerning assignment to a plan, enrollment, or disenrollment. The Contractor shall attempt to resolve the problem through the procedures for processing enrollment and disenrollment as specified in Enrollment/Disenrollment.

    a. If the Contractor is unable to resolve the problem through the procedures for processing enrollment and disenrollment the Contractor shall direct the beneficiary to the plan or other appropriate party.

    b. If the member has already contacted the health plan and the problem has not been resolved to the member's satisfaction, then the Contractor shall refer the beneficiary to the State's Medi-Cal Managed Care Ombudsman and the Department of Corporations' HMO Consumer Service.

        1) The Contractor shall advise the beneficiary that he/she can expect to receive a call or an answer from the Ombudsman within one business day after the Contractor notifies the Ombudsman of the problem.

        2) When a referral is made to the Ombudsman, the Contractor shall, within one business day, forward (fax) an incident report to the Ombudsman.

        3) The Contractor shall keep copies of all incident reports and make reports available to the State, upon request.

4) The Contractor shall review incident reports on a monthly basis and categorize, summarize, and trend problem(s). If the problem is a systems and/or operational issue, the Contractor shall issue a problem statement.

5) The Contractor shall provide translation services and communication links between the beneficiary and the Ombudsman Unit, as requested by the State.

3.5.6 CONTRACTOR RESPONSIBILITIES – CUSTOMER ASSISTANCE REPORTING

1. The Contractor shall log and maintain all inquiries made by telephone, and shall provide the State access to all telephone logs and files. Such logs and files shall be made available to the State within two business days of the State's request. For each contact, the log shall include the category of question(s) asked and action taken (e.g., resolved, referred to the State's Medi-Cal Managed Care Ombudsman, etc).

2. The Contractor shall develop and submit Daily, Weekly and Monthly reports, as defined in Reports.

3.6 ENROLLMENT / DISENROLLMENT

3.6.1 OVERVIEW

The Contractor is responsible for enrollment of beneficiaries into, and disenrollment of beneficiaries from, Medi-Cal managed care plans in specified counties. This activity includes informing beneficiaries in writing of their health plan options, processing enrollment/disenrollment forms received from beneficiaries, processing requests for exemption from plan enrollment under specified circumstances, and assigning to an available health plan those beneficiaries who do not make a choice during the initial HCO informing process. As with presentations the goal of the enrollment/disenrollment process is to provide beneficiaries with all information necessary to make an informed health plan choice, and to generate a high percentage of timely, voluntary enrollments. The Contractor shall use effective techniques to enroll the Medi-Cal population and to provide enrollment program changes, disenrollments, and exemption and assignment processing in an accurate and timely manner as required in this section and its related subsections.

3.6.2 CONTRACTOR RESPONSIBILITIES-INFORMING BENEFICIARIES

The Contractor is responsible for four distinct informing processes. These are the initial HCO informing process, the re-informing process, the annual renotification process, and other information mailings.

1. Initial HCO Informing Process

   a. Mandatory Managed Care County: One or More Operational Plans Are Available and Fee-for-Service Is Still an Option

      If the Department has received federal approval to designate one or more plans in a mandatory participation managed care county and fee-for-service is still an option, the Contractor shall implement the initial HCO informing process as described in the following subsections, and assign beneficiaries to health plans in accordance with Assignment requirements. If the Department has not yet received federal approval, the State may, at its discretion, require the Contractor to implement the initial HCO informing process without implementing the assignment process.

      1) Within 30 business days of receiving notification from the State that the county shall become a mandatory county in which fee-for-service remains an option, the Contractor shall mail a language appropriate notice to beneficiaries in mandatory aid codes, as specified by the State, informing them of any changes in plan choices, including but not limited to:

         a) The availability of the fee-for-service program,

         b) New plans available, if any, and

         c) Whether the plan in which they are currently enrolled will be a part of the Medi-Cal managed care program in that county while fee-for-service is still an option.

      2) Upon receipt of notification from the State, the Contractor shall use the HCO informing process described below to enroll beneficiaries in mandatory aid codes into the operational plan(s). During the period preceding effective enrollment, eligible beneficiaries always have the option of choosing to receive services through the fee-for-service Medi-Cal program.

b. Mandatory Managed Care County: Two or More Operational Plans Are Available and Fee-for-Service Is Not an Option

1) Within 30 business days of receiving State notification that the applicable managed care model shall be fully operational in a county in which enrollment in a managed care plan is required for beneficiaries in mandatory aid codes, the Contractor shall mail a language appropriate notice to those beneficiaries not currently enrolled in a health plan informing them of the transition and that fee-for-service will no longer be an option. This notice shall also inform beneficiaries that an informing packet shall be mailed to them explaining their health care options.

2) Beneficiaries in mandatory aid codes shall receive one of three types of notification letters, depending upon the manner in which they currently receive Medi-Cal services in the affected county, as follows:

a) A letter informing those beneficiaries currently receiving Medi-Cal services through the fee-for-service program that they must now select one of the two or more operational plans.

b) A letter informing those beneficiaries currently enrolled in managed care plans that the plan they are in is no longer available and that they must select a new plan.

c) A letter informing those beneficiaries currently enrolled that they may remain in their current plan or may change plans.

Samples of the three types of notices are included in Data Library.

3) Upon receipt of notification from the State, the Contractor shall use the initial HCO informing process, described above, to enroll beneficiaries in mandatory aid codes into the operational plans.

c. The population subject to the initial HCO informing process includes those Medi-Cal beneficiaries in mandatory aid codes in mandatory counties who are eligible for enrollment in a managed care plan. The initial HCO informing process also involves the mailing of the following three separate letters.

Exhibit 2-1 shows the current required time frames for mail-out of these letters.

1) Intent to Assign Letter

The Contractor shall include an Intent to Assign letter in each informing packet mailed to the population subject to the informing process. The letter shall describe the decision the beneficiary needs to make, the time frame for decision, and the consequences of not making a decision. For purposes of this section, the term "beneficiary" means either an individual beneficiary or the Medi-Cal case unit.

2) Intent to Default Letter

If an enrollment form is not completed and returned by the beneficiary within the established time frame, the Contractor shall mail the beneficiary an Intent to Default letter within one business day of the date the time frame expires as a reminder to complete and return the enrollment form. The Notice of Intent to Default letter shall, at a minimum, include the following information:

a) Beneficiary's name and address.

b) Reason for intention to assign beneficiary to a managed care plan by default.

c) Effective date of assignment.

d) Instructions concerning forms to be completed to prevent assignment and time frames for completing those forms.

e) Toll-free telephone number and address where the beneficiary can obtain additional information, assistance in completing the enrollment form, or a new enrollment form.

After the letter has been mailed, if an enrollment form is not received from the beneficiary within the established time frames, the beneficiary shall automatically be assigned to a plan (see Assignment). For purposes of this section, the term "beneficiary" means either an individual beneficiary or the Medi-Cal case unit.

3) Assignment Confirmation Letter

When an individual beneficiary is scheduled to be assigned automatically to a plan, the Contractor shall mail an assignment confirmation letter to the beneficiary within three business days of accepted MEDs transaction. This confirmation letter shall include the following:

a) The effective date of assignment to the plan.

b) The process to use if the assignment is not appropriate or if the beneficiary wishes to disenroll from the assigned plan.

c) The name of the plan to which the beneficiary has been assigned.

d) Toll-free telephone number where the beneficiary can receive additional assistance.

2. Re-Informing Beneficiaries

At any time during the term of this contract, new plans may be added that were not available when the beneficiary made his/her original choice. Plans may also be deleted, thus requiring some beneficiaries to select another plan. At the State's direction, the Contractor shall send a letter to all affected beneficiaries informing them of all options available. At the State's discretion, the mailing may also include plan comparative information and other informing materials. The Contractor shall re-inform beneficiaries in mandatory aid codes about new or changed health care options. At the State's direction, the Contractor shall implement the re-informing process as follows:

a. If a new health care plan is added in a specific county, the Contractor shall send the re-informing letter.

b. If a health care plan is deleted in a specific county, the Contractor may be required to:

1) Implement the initial HCO informing process as specified in above for all beneficiaries who are members of the deleted plan.

2) Send nothing to beneficiaries who are not enrolled in the deleted plan.

3) Send a letter to beneficiaries who are in the deleted plan if they will be transferred automatically to an existing plan or other state directed alternative.

If a beneficiary requests an informing packet following receipt of re-informing information, the Contractor shall send it in accordance with the requirements in Mailing Informing Packets.

3. Annual Renotification Process

The Contractor shall mail annual renotification materials to all Medi-Cal beneficiaries who have been continuously enrolled in a health care plan for 12 consecutive months. These materials shall be sent to the head of the Medi-Cal case unit, unless the individual enrolled beneficiaries are in separate plans or have not been enrolled for identical time periods, in which case the renotification materials shall be sent to each enrolled beneficiary. If a beneficiary requests an informing packet following receipt of annual renotification materials, the Contractor shall send it in accordance with the requirements in Mailing Informing Packets.

4. Other Informing Mailings

The Contractor shall be responsible for Ad Hoc mailings as specified by the State. These mailings shall include, but are not limited to; letters, post-cards, and fliers.

3.6.3 CONTRACTOR RESPONSIBLITIES-ENROLLMENT/DISENROLLMENT FORM PROCESSING

The Contractor shall process enrollments and disenrollments from beneficiaries residing in any county designated by the State. The Contractor shall enroll eligible beneficiaries into selected managed care plans, shall disenroll beneficiaries from those plans and inform the beneficiary of their health plan enrollment status in accordance with managed care enrollment criteria as provided by the State.

The Contractor shall enroll eligible beneficiaries into, or disenroll them from, selected managed care plans using the following procedure:

1. Enrollment/Disenrollment and Other Related Forms

a. The enrollment/disenrollment and other related forms, such as the medical or non-medical exemption, shall be received, opened, sorted, assigned a unique tracking number (which shall incorporate the Julian date of receipt at the Contractor's forms processing location and an indicator by form type), and distributed as appropriate within the Contractor's organization within one day of receipt by the Contractor.

b. Enrollment/disenrollment and other related forms collected from beneficiaries at an enrollment presentation shall be mailed or delivered to the Contractor's forms processing location within one business day of the date of the presentation and shall be prepared for processing in accordance with requirements above.

c. The Contractor shall accept and process the various health care model enrollment/disenrollment form editions and any revisions to forms currently in use. Forms completed by the beneficiary in another language shall be processed in the same manner as forms completed in English. The Contractor shall translate information on the forms to English as necessary to meet this processing requirement.

d. The Contractor shall accept and process, as directed, other related forms forwarded by the State or any other entity as defined by the State.

e. The Contractor shall review enrollment/disenrollment and other related forms for accuracy and completeness of information in order to determine whether and to what extent the information provided is sufficient for processing. The Contractor is required to attempt to record the receipt and disposition of each enrollment/disenrollment or other related form in the Contractor's HCO system even if the information is not sufficiently complete or accurate to allow for the completion of the requested enrollment/disenrollment.

f. The Contractor shall develop and maintain a log of "non-processable" enrollment/disenrollment or other related forms. At a minimum, the log shall contain the unique identification number assigned above, beneficiary name, address, and form disposition, i.e. date form/letter mailed to sender. For those forms with insufficient information to enter into the system, the Contractor shall mail the original form to the beneficiary within one business days of receipt, with a language appropriate letter specifying areas that are incomplete or incorrect, and requesting

the beneficiary to complete/correct the form and resubmit for processing.

g. If the information is sufficient to allow further processing, the Contractor shall enter the data contained in the required and optional fields of the enrollment/disenrollment or other related forms into the Contractor's HCO system. Sufficiently complete forms that allow data entry into the HCO system shall be defined as a "processable" form.

The Contractor shall ensure that all applicable information provided on the enrollment/disenrollment and other related forms is entered into the Contractor's system, including but not limited to: beneficiary name; Client Index Number (CIN); Social Security Number (SSN), and telephone number; plan choice; pregnancy due date; plan affiliate; provider/clinic name; and provider identification number.

1) The data shall be entered into the Contractor's system using key data entry, document scanning, or other State approved data entry methods.

2) The Contractor shall maintain an enrollment/disenrollment and other related forms data entry accuracy rate of 99 percent per month for all required fields (SSN and plan choice) where information necessary to make a correct assignment to a plan or disenrollment from a plan is provided on the form. The Contractor shall maintain an enrollment form data entry accuracy rate of 99 percent per month for all remaining fields.

3) The Contractor shall ensure that only one enrollment and/or disenrollment transaction per plan type per day (i.e. medical, dental, etc.) is entered into the Contractor's system for each beneficiary listed on each enrollment/disenrollment form received.

4) If the Contractor is unable to match beneficiary information from an enrollment/disenrollment form with information on MEDS, the Contractor shall use the name, address, and/or date-of-birth from the enroll/disenroll or other related form to create a beneficiary record in the HCO system pending a potential future MEDS data submission.

2. If the enrollment/disenrollment form is incomplete or incorrect, the Contractor shall mail it to the beneficiary within one business day after entering the transaction into the Contractor's HCO system with a letter specifying areas that are incomplete or incorrect, and requesting the beneficiary to complete and return the form. If State criteria are not met, a form shall be considered incomplete.

   a. If the incomplete form is for an enrollment and the beneficiary is on the assignment path, the time period for completing the enrollment shall be extended by ten additional calendar days to allow the beneficiary time to correct and return a completed form. If the form is not returned, the beneficiary shall continue on the assignment path.

   b. If the incomplete form is for a disenrollment, the letter to the beneficiary shall state that a response must be submitted within thirty days or the request for disenrollment shall not be processed. The Contractor shall hold all pended incomplete or incorrect disenrollment requests for 30 business days. If the additional required information or corrections are not received within the 30-day period, the Contractor shall place a notation in the beneficiary file and cancel the disenrollment request.

   c. The Contractor shall review each returned form and, if complete, the enrollment or disenrollment shall be processed as specified above.

3. Beneficiary Enrollments/Disenrollments

   The Contractor shall enroll/disenroll beneficiary into and out of plans in accordance with State policies and criteria on beneficiary managed care participation. The Contractor shall transmit to the State for processing only those beneficiaries who meet the following criteria.

   a. The Contractor shall confirm the beneficiary's eligibility to enroll in a health plan of choice by reviewing relevant information, including but not limited to:

      1) Current Medi-Cal eligibility in mandatory/voluntary aid codes,

      2) Appropriateness of the beneficiary's county and ZIP code for requested plan, and

      3) Requested plan's capacity to accept the beneficiary.

If the beneficiary meets managed care plan eligibility requirements, the enrollment shall be processed.

b. A disenrollment shall not be processed if enrollment is mandatory and the beneficiary has not indicated a new choice. If a new choice is not indicated, the form shall be processed as incomplete or incorrect pursuant to requirements above. The Contractor shall track and report on disenrollment requests submitted by mandatory beneficiaries that are incomplete because a new choice is not made.

c. If the beneficiary is eligible in a voluntary aid code or resides in a county where fee-for-service is still an option, the Contractor shall process the disenrollment in the following manner:

1) Disenroll the beneficiary from the current managed care plan.

2) Do not enroll the beneficiary into another plan if fee-for-service was indicated as the choice, or

3) Enroll the beneficiary into the new managed care plan if a plan was chosen on the enrollment/disenrollment form.

d. The Contractor shall complete processable enrollment and/or disenrollment transactions within two business days of receiving an enrollment/disenrollment form. The two business days for a complete enrollment or disenrollment shall be measured from the date the Contractor receives a form until the transaction is entered and accepted into the Contractor's HCO system.

e. The Contractor shall submit enrollments and disenrollments to MEDS within one business day after the transaction has successfully processed through the Contractor's HCO system using a format defined by the State and in a methodology proposed by the Contractor and approved by the State. For an enrollment/disenrollment transaction to be successfully processed means it has met all of the managed care enrollment criteria as defined by the State. The Contractor shall use the Contractor's system to submit the transactions to the State, unless the enrollment/disenrollment form is received on the day prior to or the day of MEDS renewal. In this case, the Contractor may submit enrollments and disenrollments via on-line transactions to MEDS. The Contractor shall enter each transaction submitted on-line to MEDS into the HCO system within one day of the MEDS on-line processing. Processing and beneficiary notification requirements for on-line MEDS

transactions are the same as for batch transaction processing and notification. However, this latter system entry shall not be considered a payable transaction.

f. For each enrollment, the Contractor shall mail a confirmation letter to the beneficiary one day after the enrollment transaction is accepted by MEDS, confirming the pending enrollment and identifying plan name and effective date of enrollment. For each disenrollment, the Contractor shall mail a pending disenrollment letter to the beneficiary one day after MEDS has accepted the disenrollment transaction confirming the disenrollment and the choice of the new managed care plan (or fee-for-service, if applicable), identifying the plan name and effective date of disenrollment/enrollment.

g. If the form is complete, but the beneficiary does not meet one or more of the managed care participation eligibility requirements, the Contractor shall process the enrollment/disenrollment as follows:

1) If there is no current Medi-Cal eligibility in a mandatory/voluntary aid code found the Contractor shall repeat the eligibility verification check daily for 120 days until:

a) Appropriate eligibility is verified, at which time the Contractor shall complete the transaction; or

b) No appropriate eligibility is found after 120 days, at which time the Contractor shall not process the transaction. The Contractor shall retain forms from unprocessed transactions as specified in Records Retention and Retrieval.

2) If the beneficiary's ZIP code is inappropriate for the requested plan or the plan's language or enrollment capacity is insufficient, the Contractor shall mail the original form to the beneficiary within two business days after processing it with a letter identifying the reason the request for enrollment was rejected. For beneficiaries on the assignment path, the time period for completing an enrollment shall be extended an additional ten calendar days to allow the beneficiary time to correct and return a corrected form.

i. In Fee-for-Service Managed Care Networks (FFS-MCN), the Contractor shall process disenrollments for any beneficiary who submits an exemption form self-certifying that he/she is not required to participate in the fee-for-service managed care plan program due to a medical condition that qualifies him/her to be exempt from enrollment. In FFS-MCN, the Contractor shall also be responsible for processing disenrollments for voluntary beneficiaries who submit an opt-out form, indicating they are not required to participate in the FFS-MCN program.

Note: Currently neither disenrollment forms or exemption forms are processed by the Contractor for FFS-MCN counties and plans. Disenrollment forms are processed by the county/plans. However, the Contractor shall accept a file containing exemptions from FFS-MCN that shall be posted to the Contractor's system to prevent future enrollments.

j. The Contractor shall retroactively disenroll beneficiaries who meet the necessary criteria, as determined by the State. The Contractor shall submit, via on-line MEDS, the disenrollment transaction in which the month of disenrollment is current or one month prior, within two business days of receipt of the request or as otherwise instructed by the State. All other retroactive disenrollment requests shall be submitted to the State for approval. The Contractor shall forward these requests to the State via fax or courier no later than one business day following receipt. Upon receipt of a State-approved retroactive disenrollment, the Contractor shall process within two business days, via on-line MEDS, the retroactive disenrollment transaction. The Contractor shall enter each approved retroactive disenrollment into the HCO system and shall mail a letter to the beneficiary confirming approval of the retroactive disenrollment request within one business day of the date MEDS accepts the pending disenrollment transaction. However, this latter system entry shall not be considered a payable transaction.

For denied retroactive disenrollments, the Contractor shall return the request to the originator with a letter indicating the reason for the denial within two business days after receipt of the State's disapproval. The Contractor shall send a copy of the denial letter to the beneficiary on the same date that the letter is sent to the originator.

k. The Contractor shall process expedited disenrollments for beneficiaries that meet the necessary criteria, based upon State

guidelines. All expedited disenrollment forms shall be submitted via on-line MEDS no later than two business days after date of receipt of all necessary documents as determined by the State. The Contractor shall enter each approved expedited disenrollment into the HCO system and shall mail a letter to the beneficiary confirming approval of the expedited or emergency disenrollment request within one business day of the date MEDS accepts the pending disenrollment transaction. However, this latter system entry shall not be considered a payable transaction.

For denied expedited disenrollments, the Contractor shall mail the request back to the originator with a letter indicating the reason for the denial within two business days after disapproval by the Contractor or receipt of the State's disapproval. The Contractor shall mail a copy of the denial letter to the beneficiary on the same date that the letter is sent to the originator.

l. On a weekly basis the Contractor shall return a copy of completed enrollment forms to the respective Managed Care plans.

3.6.3.1 Alternatives to Plan Enrollment

The requirements presented in this section reflect current Medi-Cal program policy. Should the State change its policies in this area, the Contractor shall implement them as part of its fixed price.

1. Medical Exemption Processing

The Contractor shall receive medical exemption request forms requesting that a beneficiary remain in the fee-for-service Medi-Cal program as a result of a medical condition. The Contractor shall process medical exemption requests in accordance with policies and procedures developed and provided by the State.

a. The Contractor shall capture and retain data elements from the forms as directed by the State.

b. The State shall publish and furnish to the Contractor a list of medical conditions that qualify the beneficiary for a medical exemption. Based on this list, the Contractor shall have the capability to systematically edit the request.

c. The Contractor shall verify physician's license numbers and Medi-Cal billing numbers via the Provider Master File (PMF) or

other verification as directed by the State (e.g. State Licensing Boards). Access to PMF shall be provided by the State.

d. The Contractor shall process original requests and corrected forms for medical exemption within three business days of receipt.

e. The Contractor shall approve the written request for a medical exemption if all of the following State criteria are met:

1) The medical exemption form is complete.

2) The medical condition meets the State criteria for approval.

3) Treatment must have begun or been scheduled prior to the date of enrollment.

4) The beneficiary has been enrolled in a plan for less than 60 days or is not currently enrolled in a plan.

5) The beneficiary is in an eligible mandatory or voluntary aid code.

6) The physician is not affiliated with a Medi-Cal managed care plan in the county of the beneficiary.

f. If the medical exemption request is not complete the Contractor shall defer the request.

To process a deferred medical exemption request, the Contractor shall:

1) Pend the request in the Contractor's system.

2) FAX the original request, within one business day of entering this information into the system, to the requesting provider or physician along with a letter describing the missing information or documentation. The letter shall also include information on how to return the corrected form or additional documentation, how to contact the Contractor if the physician has questions, and the due date for return of the requested information.

3) If the beneficiary is not currently enrolled in a plan and is on the assignment path, extend the time period for completing the medical exemption request by ten additional calendar days to allow the physician time to correct and return a completed form. If the form is not returned, the beneficiary shall continue on the assignment path.

4) Receive corrections or additional requested documentation and complete the processing of the medical exemption request in accordance with this section.

5) Deny the medical exemption request if it is not returned within ten business days of the date the Contractor sends the letter requesting additional information.

g. If the type of medical exemption requested is not included on the published list of medical conditions but the proper documentation is present, the Contractor shall forward the request and documentation to the State within one business day of receipt for State action. If the State approves the request for medical exemption, the Contractor shall complete the transaction within two business days of receipt of the State's approval.

Certain exemptions may require that they be put in "pend" status and forwarded to the State for review and approval/denial. Criteria for exemptions subject to this process shall be specified by the State.

h. If the medical exemption request does not meet the conditions for approval or any other requirements that may be imposed by the State, the Contractor shall deny the request.

i. If the Contractor or the State approves the Request for Medical Exemption, and

1) If the beneficiary is currently enrolled in a plan, the Contractor shall disenroll the beneficiary on-line in MEDS within one business day of approving the request. The Contractor shall enter the disenrollment into the HCO system and shall mail a letter to the beneficiary confirming approval of the medical exemption within one business day of the date MEDS accepts the pending disenrollment

transaction. However, this latter system entry shall not be considered a payable transaction, or

2) If the beneficiary is on the assignment path, the Contractor shall remove the beneficiary from that path and mail a letter to the beneficiary confirming approval of the medical exemption within one business day of the approval.

j. If the Contractor denies the Request for Medical Exemption, a denial letter shall be mailed back to the beneficiary within three-business day of entering the denial into the Contractor's system. If the State denies the request, the Contractor shall enter the denial into its system and mail the request back to the beneficiary with a denial letter, within three business days of receiving the State's denial. The denial letter shall indicate the reason for the denial and shall meet the requirements of the Jackson v. Rank court decision, as specified by the State.

k. The Contractor shall track the exemption period for all beneficiaries who have been granted a medical exemption, and shall report these beneficiaries on the Monthly Management Report. The Contractor shall initiate the enrollment process for all beneficiaries whose medical exemption has expired on the enrollment path within one business day of the expiration of their medical exemption.

2. Non-Medical Exemption/American Indian Exemption

a. The Contractor shall receive requests for exemption from enrollment in a plan from individuals receiving services from an Indian Health Service facility and shall process them in accordance with State requirements. A disenrollment form must accompany this request.

b. The Contractor shall approve the request for a Non-medical exemption if all of the following criteria are met:

1) The beneficiary chooses to receive health care services through an Indian Health Service facility, and

2) The beneficiary has written acceptance from an Indian Health Service facility.

c. The Contractor shall deny the Non-medical exemption request if the conditions of b. above are not met.

d. If the Contractor or the State approves the Request for a Non-medical exemption, and

1) If the beneficiary is currently enrolled in a plan, the Contractor shall disenroll the beneficiary on-line in MEDS within one business day of approving the request, retroactive to the first day of the current month. The Contractor shall enter the disenrollment into the HCO system and shall mail a letter to the beneficiary confirming approval of the exemption within one business day of the date MEDS accepts the pending disenrollment transaction. However, this latter system entry shall not be considered a payable transaction, or

2) If the beneficiary is on the assignment path, the Contractor shall remove the beneficiary from that path and mail a letter to the beneficiary confirming approval of the exemption within one business day of the approval.

e. If the Contractor denies the Non-medical exemption request, it shall be returned to the beneficiary along with a denial letter within one business day of entering the transaction into the Contractor's system. The denial letter shall indicate the reason for the denial and shall meet the requirements of the Jackson v. Rank court decision, as specified by the State.

f. The Contractor shall track and report to the State all beneficiaries who have been granted a Non-medical exemption on the Monthly Management Report.

3. Non-Medical Exemption: Wavier Program Exemption

a. The Contractor shall receive requests for exemption from enrollment in a plan from beneficiaries eligible to receive skilled nursing services at home through a Medi-Cal waiver program. The State shall publish a list of Medi-Cal waiver programs that qualify beneficiaries for a wavier program exemption, and shall furnish the list to the Contractor.

b. The Contractor shall approve the request for a wavier program exemption if all the following criteria are met:

1) The beneficiary is eligible to receive health care services through a Medi-Cal waiver program.

2) A Medi-Cal FFS provider certifies that the beneficiary has been accepted for participation in a Medi-Cal wavier program.

c. The Contractor shall deny the Waiver Program exemption request if the conditions of b. above are not met.

d. If the Contractor or the State approves the Request for Waiver Program exemption, and

1) If the beneficiary is currently enrolled in a plan, the Contractor shall disenroll the beneficiary on-line in MEDS within one business day of approving the request, retroactive to the first day of the current month. The Contractor shall enter the disenrollment into the HCO system and shall mail a letter to the beneficiary confirming approval of the exemption within one business day of the date MEDS accepts the pending disenrollment transaction, or

2) If the beneficiary is on the assignment path, the Contractor shall remove the beneficiary from the path and mail a letter to the beneficiary confirming approval of the exemption within one business day of the approval.

e. If the Contractor denies the Waiver Program exemption request, a denial letter shall be mailed to the beneficiary within one business day of entering the transaction into the Contractor's system. The denial letter shall indicate the reason for the denial and shall meet the requirements of the Jackson v. Rank court decision as specified by the State.

f. The Contractor shall track and report to the State all beneficiaries who have been granted a Waiver Program exemption in the Monthly Management Report.

4. Dental Exemption Processing

The Contractor shall receive dental exemption request forms and documentation indicating a beneficiary qualifies to remain in the fee-for-service Medi-Cal program as a result of a dental condition. The Contractor shall process dental exemption requests in accordance with policies and procedures developed and provided by the State.

a. The Contractor shall receive and transmit to the State daily, via facsimile, all dental exemption request forms received in the

previous 24-hour period, with a cover sheet listing the exemption requests to be reviewed by the State.

b. If the State approves the request for dental exemption, and

1) If the beneficiary is currently enrolled in a dental plan, the Contractor shall disenroll the beneficiary on-line in MEDS within one business day of approving the request, retroactive to the date of the default assignment or to 60 calendar days prior to the first day of the current month, whichever is later. The Contractor shall enter the disenrollment into the HCO system and shall mail a letter to the beneficiary confirming approval of the exemption within one business day of the date MEDS accepts the pending disenrollment transaction. However, this latter system entry shall not be considered a payable transaction, or

2) If the beneficiary is on the assignment path, the Contractor shall remove the beneficiary from that path and mail a letter to the beneficiary confirming approval of the exemption within one business day of the approval.

c. If the State denies the dental exemption request, the Contractor shall enter the denial into its system and return the request to the beneficiary with a denial letter, within two business days of receiving the State's denial. The denial letter shall indicate the reason for the denial and shall meet the requirements of the Jackson v. Rank court decision, as specified by the State.

c. The Contractor shall track the exemption period for all beneficiaries who have been granted a dental exemption, and shall report these beneficiaries on the Monthly Management Report. The Contractor shall place all beneficiaries whose dental exemption has expired on the enrollment path within five business days of the expiration of their dental exemption.

5. Other Exemption Processing

a. The Contractor shall receive requests for exemption from enrollment from the State for individuals who have been disenrolled from their plan due to non-compliant behavior.

b. The Contractor shall flag all such individuals and prevent initiation of enrollment material and/or enrollment.

c. The Contractor shall track and report to the State all beneficiaries who have been granted extensions to enrollment due to non-compliant behavior on the Monthly Management Report.

6. Tracking Exemption Processing

In cases where a single provider has requested more than 25 exemptions, regardless of the time frame for those exemptions, the Contractor shall generate a report listing of the provider and the beneficiaries requesting exemptions. The Contractor shall also provide a report of all exemption requests submitted to the State for review.

These reports shall contain at a minimum:

- SSN/CIN
- Beneficiaries name
- Provider number
- Doctor submitting exemption
- Date received
- Date forwarded to State for review
- Current disposition

Additionally the Contractor shall provide a trending report as specified by the State regarding all fields on the Medical Exemption form.

The Contractor shall provide an exemption tracking report within a week from the date of such an occurrence as pursuant to Weekly Narrative Reports requirements.

3.6.3.2 Assignment

The Contractor shall assign beneficiaries to the various types of managed care models, or pilot projects as required by the State.

1. Requirement to Assign

If a beneficiary in a mandatory aid code does not make a choice within the time period established by the State, or does not submit a valid exemption request within that time frame, the Contractor shall assign that beneficiary to an available and appropriate managed care plan that meets managed care assignment requirements as specified by the State. The Contractor shall notify beneficiaries in writing, no later than two (2) business day after the enrollment transaction is accepted by MEDS, of their assignment and the effective date of that assignment.

The Contractor shall also advise beneficiaries of the process to use if they wish to disenroll from their assigned plan and enroll in other available plans or fee-for-service (FFS), if applicable.

2. Criteria for Assignment

When a beneficiary is assigned to a plan, a weighted assignment method shall be used to determine the plan to be assigned. Considerations that apply include, but are not limited to, the following:

a. A beneficiary shall only be assigned to a managed care plan with a primary care service site in the same ZIP code as the beneficiary's residence.

b. A beneficiary shall be assigned to the same managed care plan as:

1) That in which he/she was previously enrolled.

2) Head of household (case head) or, if the case head is not enrolled in a plan,

3) Another family member.

c. A beneficiary shall be assigned to a managed care plan in which he/she is eligible to enroll. This includes:

1) A managed care plan that has capacity to accept new patients.

2) A managed care plan that provides services to those persons in the aid code of the applicant.

3) A managed care plan that has language capability to meet the beneficiary's needs.

4) An available primary care provider who is within a ten-mile radius of the beneficiary's residence.

d. The Contractor shall adhere to the State's algorithms for assignment of beneficiaries to the various health plans in each county, pursuant to State regulations and written directives. Information on the current State assignment algorithms is included in the Data Library.

3.7 QUALITY ASSURANCE REQUIREMENTS

3.7.1 OVERVIEW

The Contractor shall establish a comprehensive quality assurance program to verify that contract requirements are met; internal processes are monitored and evaluated for appropriate health plan enrollments and disenrollments; HCO system or operations problems are identified and corrected in a timely manner; HCO policies are effectively and efficiently implemented; and that State needs are met.

3.7.2 QUALITY ASSURANCE ACTIVITIES-CONTRACTOR RESPONSIBILIIES

3.7.2.1 Quality Assurance Plan

1. The Contractor shall develop and maintain a Quality Assurance Plan describing the methods by which the Contractor and subcontractors shall ensure that contract requirements are met and that the ongoing process of improving the performance of the Contractor's operation remains effective. The Plan shall incorporate employee involvement in quality improvement through incentive and recognition programs. This Plan shall identify:

    a. The Quality Assurance organizational structure and the processes involved in exchanging data both internal to the Contractor and external to the State;

    b. The data sampling tools and procedures used to evaluate Contractor operations;

    c. The preventative measures used to identify, research, and report on the causes of problems which, if resolved, would increase the efficiency and accuracy of the Contractor's operation; and

    d. The procedures used to evaluate and improve staff performance.

    The Plan shall be subject to State review and approval; however, the Contractor shall adhere to the requirements whether or not the Plan has been approved by the State. This Plan shall be updated for State approval according to the requirements in Quality Assurance of Takeover.

3.7.2.2 Quality Assurance Unit

1. The Contractor shall organize and maintain, for the term of the contract, a Quality Assurance (QA) unit to coordinate, conduct, and report on the quality assurance activities. The QA unit shall be a separate and centrally located management unit reporting directly to the Contractor Representative. No other Contractor organizations shall report to the QA unit. The QA unit shall have staff with the required levels, classifications and appropriate qualifications to carry out all QA functions. It is not a requirement that QM staff perform all of the quality or compliance validation fieldwork. The QM Plan may propose delegating specific quality or compliance validation fieldwork to other specified Contract staff. However, if this is proposed, the plan must outline the QM units over site and methods to independently validate the fieldwork of QA staff. The Contractor shall include a proposed QM staffing plan in the updated Quality Management Plan submitted for State review and approval during Takeover. The Contractor may not use hourly reimbursed special groups or cost reimbursed staff to perform required QA activities.

   The QA unit shall measure and review Contractor and subcontractors performance of each contract responsibility, report to the State and Contractor regarding compliance, interface with State-monitoring activities, and oversee any correction action. Responsibilities shall include but not be limited to:

   a. Reactive measurement and reporting of system and operations performance, and proactive review and recommendation on HCO operations policy and procedures.

   b. Identification and tracking of systems, operations, and/or performance problems.

   c. Communication and dissemination of quality assurance and improvement information throughout all levels of Contractor and subcontractors operations, and to the State.

   d. Prepare and submit required reports to the State under the signature of the Contractor's Representative.

   e. At the Department's request make available any working papers that supports any or all Quality Assurance findings.

3.7.2.3 Quality Assurance Procedure & Standard Manual

3. The Contractor shall formally document the Quality Assurance procedures, internal standards, and methodologies in a Quality Assurance Procedures and Standards Manual to be made available to its employees and to the State. The manual shall be continuously

updated and maintained to reflect all new processes, changes, and new methodologies to current processes. Updates shall occur no later than 30 business days following implementation of the new or modified process.

The procedure manual shall be developed to encompass the entire Quality Assurance Program with internal quality assurance standards. The Contractor shall adhere to the following requirements to ensure maximum employee use of the manual:

a. The manual shall be a guideline that includes internal performance standards and error rate limits for employees in each area of the Contractor's and subcontractors operation.

b. The manual shall be incorporated into the everyday operations of all units within the Contractor's and subcontractors operation. The manual or its pertinent excerpts shall be made available to all new employees as a training and reference tool in each applicable work area(s).

3.7.2.4 Quality Management Review

1. The Contractor's quality assurance review shall include continuous and routine measurement of contract work to determine the Contractor's compliance with all contract requirements. The compliance requirements include accurate and timely performance in each area of Contractor responsibility.

2. The Contractor shall set internal standards for accuracy and timeliness of each subtask and work location utilized to meet overall contract requirements. The internal standards shall be subject to State review, but not approval; in no way shall a Contractor's quality standard relieve the Contractor from meeting contract requirements. These internal standards shall be included in the Contractor's Quality Assurance Procedures and Standards Manual. Internal performance standards shall be monitored along with the review for Contractor compliance with contract requirements.

3. The Quality Assurance Unit shall specify methods to monitor Contractor and subcontractor performance appropriate to the function being tested. Monitoring shall be performed on a systematic schedule to determine the reliability of the Contractor's system in meeting contract requirements. All sampling must ensure statistical reliability at a 95 percent confidence level with not more than a two per cent error

rate. The sample size shall be based on actual volumes of workload for the month prior to the report month or the second month prior to the report month, (e.g. informing packets, enrollment/disenrollment transactions). When calculating performance rates, the results shall be displayed to two decimal places. The methodology for testing shall be explained in step-by-step detail in the Contractor's Quality Assurance Procedures and Standards Manual.

4. In the QA review and reporting process it is neither sufficient nor desirable for errors to be attributed to human error. Rather, the Contractor shall provide additional review and research of the processes it uses to determine the cause of the errors and to develop the systematic means to eliminate the source of these errors. The review and reporting process shall always identify the source of the problems, whether it is a human, operational, procedural or systems error. If the QA report identifies a system/process is not operating as designed or intended, a problem statement shall be opened pursuant to requirements in Contractors Responsibilities-Problem Correction System.

3.7.2.4.1 Monthly Performance Sampling

1. The Contractor shall aggregate all Qualtiy Assurance performance outcome data in a Monthly Quality Assurance Performance Report. The Contractor shall submit the report to the State no later than the last business day of the month following the reporting month.

2. The Contractor shall ensure that the report is accurate and thorough and includes all QA activities and methodologies outlined in the State-approved Quality Assurance Plan.

3. The Contractor shall report errors found, project those errors into overall error rates for the sampled area, and translate the errors into error types. If the report identifies compliance rates less than contract requirements, the report shall include a recommended plan for corrective action for each area out of compliance.

4. The State shall have access, upon request, to the Contractor's QA working papers.

5. Each monthly report shall include reviews or tests and reports on the following system or operations functions. Reviews or tests shall be conducted as specified below:

    a. Informing packet – A sample shall be taken throughout the month for informing packets processed during the month.

1) Content Accuracy – The Contractor shall determine the monthly accuracy rate for informing packet contents. The test shall compare the contents of the sample packets with the approved control binders to determine a daily quality assurance rate.

2) Processing Timeliness – The Contractor shall determine the monthly processing time to mail the informing packets. Processing time is defined as the number of business days to mail an informing packet from receipt of an eligible beneficiary on the Daily HCO file or identified through the monthly MEDS reconciliation process to delivery of the packet to the USPS.

b. Annual renotification mailing - A sample shall be taken throughout the month for annual renotification mailings processed during the month.

1) Content Accuracy – The Contractor shall determine the monthly accuracy rate for annual renotification mailing contents. The test shall compare the contents of the sample mailing with the approved control binders to determine a daily quality assurance rate.

2) Processing Timeliness – The Contractor shall determine the monthly processing time to mail the annual renotification mailings. The Contractor shall determine the number of business days to mail a renotification mailing from the 12-consecutive-month plan enrollment anniversary date of an eligible enrolled beneficiary to the delivery of the packet to the USPS.

c. Enrollment/Disenrollment Form Processing - A sample shall be taken of the batch enrollment/disenrollment forms processed for the month.

1) Processing Accuracy – The Contractor shall compare the sampled original form with the information entered or scanned into the system for accuracy. The Contractor shall determine the monthly processing accuracy rate for enrollment/disenrollment forms. The Contractor shall include in the report a list of forms, by beneficiary name, Social Security Number, county and unique identification number assigned to the form as part of the Contractor's enrollment/disenrollment process, for which an accuracy

error occurred, as well as the status of any specific corrective action taken and submit a problems statement pursuant to requirements in Problem Correction System Procedures for any sampled form on which an accuracy error occurred.

2) Processing Timeliness – The Contractor shall calculate the processing time for the batch-processed enrollment/disenrollment forms. The processing time shall be measured from the date the Contractor receives the form to the date the transaction is entered and accepted into MEDS (excluding authorized days for returned forms).

3) Pending Enrollment Confirmation Letters – The Contractor shall calculate the processing time for the preparation and delivery to the USPS of the enrollment transaction confirmation letters.

4) Pending Disenrollment Letters – The Contractor shall calculate the processing time for the preparation and delivery to the USPS of the disenrollment transaction disenrollment letters.

5) Disenrollment By Mandatory Beneficiary – The Contractor shall report by beneficiary name and Social Security Number any disenrollment transaction found in the sample by a mandatory beneficiary that did not also result in the re-enrollment in a managed care plan.

6) Weekly Diskette/Bulletin Board System – Of the sampled original forms, the Contractor shall review the weekly diskette or Bulletin Board System to ensure the weekly reports to the plans of completed enrollments and disenrollments are produced and distributed timely and accurately.

d. Expedited and Retroactive Disenrollment Processing - A sample shall be taken of both the expedited and retroactive disenrollments for the month.

1) Processing Accuracy – The Contractor shall compare the sampled original form with the information entered on-line to MEDS and entered or scanned into the HCO system for accuracy. The Contractor shall calculate the processing accuracy rate for the month for expedited and

retroactive disenrollment requests. The Contractor shall include in the report a list of forms, by beneficiary name, Social Security Number, county and unique identification number assigned to the form as part of the Contractor's enrollment/disenrollment process, for which an accuracy error occurred, as well as the status of any specific corrective action taken for any sampled form on which an accuracy error occurred.

2) Appropriate Processing – The Contractor shall validate the sample against the expedited disenrollment or retroactive disenrollment criteria as determined by the State. The Contractor shall calculate the compliance rate with processing criteria, and report any sampled form on which a processing error occurred by beneficiary name, Social Security Number, county, and unique identification number assigned to the beneficiary as part of the Contractor's expedited disenrollment process.

3) Processing Timeliness – The Contractor shall calculate the processing time for the on-line-processed expedited and retroactive disenrollment forms. The completion time shall be measured from the date the Contractor receives the form to the date the transaction is entered and accepted into MEDS (excluding authorized days for returned forms).

4) Expedited and Retroactive Pending Disenrollment Letters – The Contractor shall calculate the processing time for the preparation and delivery to the USPS of the disenrollment transaction disenrollment letters.

5) Weekly Diskette/Bulletin Board System – Of the sampled original forms, the Contractor shall review the weekly diskette or Bulletin Board System to ensure the weekly reports to the plans of expedited disenrollments are produced and distributed timely and accurately.

e. Medical and Dental Exemption Processing - A sample shall be taken of the requests for medical and dental exemption processed for the month.

1) Processing Accuracy – The Contractor shall compare the sampled original form with the information entered or scanned into the HCO system for accuracy. The Contractor shall calculate the processing accuracy rate

for the month for the medical and dental exemptions. The Contractor shall include in the report a list of forms, by beneficiary name, Social Security Number, county and unique identification number assigned to the form as part of the Contractor's enrollment/disenrollment process, for which an accuracy error occurred, as well as the status of any specific corrective action taken for any sampled form on which an accuracy error occurred.

2) Appropriate Processing – The Contractor shall validate the sample against the medical or dental exemption criteria as determined by the State. The Contractor shall calculate the compliance rate with processing criteria and include in the report a list of forms, by beneficiary name, Social Security Number, county and unique identification number assigned to the form as part of the Contractor's enrollment/disenrollment process, for which an accuracy error occurred, as well as the status of any specific corrective action taken for any sampled form on which an accuracy error occurred.

3) Monitoring Exemption Period – The Contractor shall review a sample of the universe of beneficiaries with medical and dental exemptions to ensure they are still within their exemption period. The Contractor shall calculate the compliance rate with exemption period criteria. If the report identifies any beneficiaries with an expired medical or dental exemption not on the enrollment path, the Contractor shall include a recommended plan of corrective action. The Contractor shall also report any beneficiary who is still shown as exempted but whose exemption period has ended by beneficiary name, Social Security Number, county, and unique identification number assigned to the beneficiary as part of the Contractor's medical or dental exemption process. In addition, the Contractor shall review a sample universe of the Medical and Dental exemptions to ensure notification of expiration took place 2 days in advance.

4) Processing Timeliness - The Contractor shall calculate the processing time for the medical and dental exemption forms. The processing time shall be measured from the date the Contractor receives the form to the date the transaction is entered and accepted into MEDS

(excluding authorized days for returned forms or days pending input/resolution from State).

5) Medical and Dental Exemption Approval/Denial Letters - The Contractor shall calculate the processing time for the preparation and delivery to the USPS of the medical and dental exemption approval/denial letters.

f. Beneficiary's Assignment - A sample shall be taken of beneficiaries assigned to a managed care plan for the month.

1) Appropriate Assignment –The Contractor shall test the sample to ensure the assignment meets all requirements outlined in Assignments. The Contractor shall calculate the accuracy of the assignment by the various requirements, i.e., appropriate ZIP code, same as other family members, etc.

2) Assignment Notification and Processing Time – The Contractor shall calculate the processing time for the preparation and delivery to the USPS of the assignment notifications.

3) Assignment Algorithms – The Contractor shall verify 100 percent of the assignment algorithm system logic to the most recent policy directives received from the State. Initiate immediate corrective action if any discrepancies are identified. The corrective action shall include notifying the State and opening a problem statement.

g. Data File Updates

1) Daily HCO and Monthly Reconciliation Files - A sample of beneficiaries shall be taken from both the Daily HCO and Monthly Reconciliation File received during the month. The Contractor shall calculate the accuracy rate against the eligibility criteria for HCO processing, and include in the report a list any beneficiaries, by name and Social Security Number, for which an accuracy error occurred.

2) HCO Transaction Log File – A sample of transactions shall be taken from the HCO Transaction Log File. The Contractor shall calculate the accuracy of disposition for the various MEDS processed transactions, e.g.

appropriate updating to HCO system, resolution of denied transactions.

3) Monthly Project Control Table – A sample of updates shall be taken for the monthly project control table. The Contractor shall calculate the accuracy rate of the project control updates to the HCO system.

h. Returned Informing packets – A sample shall be taken from informing packets sent to beneficiaries which has been returned by the USPS.

1) Processing Timeliness - The Contractor shall calculate the processing time for the returned informing packets. The processing time shall be measured from the date the Contractor receives the returned mail from the USPS until appropriate action is taken in the HCO system, e.g. remove beneficiary from the assignment path.

2) Re-stocking of Materials – The Contractor shall calculate the processing time for the re-stocking of re-usable informing packet materials. The processing time shall be measured from the date the Contractor receives the returned mail from the USPS until the re-usable materials are returned to inventory and the inventory system is updated.

i. Reports – A sample shall be taken of reports required to be produced and delivered during the month.

1) Timeliness – The Contractor shall verify that reports, both internal and external, were produced and distributed in accordance with requirements.

2) Accuracy – The Contractor shall test the reports accuracy.

j. Records Retention and Retrieval - A sample shall be taken of received enrollment/disenrollment forms for the following time periods: 15 to 30 days old, 31 to 90 days old, 91 – 150 days old, older than 151 days. The Contractor shall verify the timely access and retrieval of the original forms or their facsimile.

If the Contractor proposed and the State accepted the substitution of microfilm/microfiche or other media in lieu of maintaining the original documents, the Contractor shall test the

quality of the media against the standards and requirements of Records Retention and Retrieval (Subsection 3.10.6).

k. Telephone Monitoring/Content Accuracy – Ensure all CSR's are providing correct and timely information to beneficiaries via telephone monitoring.

Reviews of other processes may be done on a periodic basis, but no less than once every six months. The Contractor's Quality Assurance Procedures and Standards Manual shall list each Contractor operations requirement, list sub-components of each requirement, and include schedules and the specific methods to be used to monitor system performance for each area. The State shall have authority to review and approve these schedules and methods throughout the life of the contract.

3.7.2.4.2 Special Quality Assurance Studies

The Contractor shall perform State-directed special quality assurance studies. A study shall constitute approximately 60 work hours. These studies shall not exceed six per contract year. The Contractor shall develop the study requirements and methodology and submit it for State approval within ten business days of receipt of the study request from the State. The Contractor shall complete the study as directed and forward the findings to the State within 30 business days of State's approval of the study requirements and methodology. Data Processing support or ad hoc reports needed for the special quality assurance studies shall be reimbursed pursuant to requirements of Operations Invoice.

3.7.3 CONTRACTOR RESPONSIBILITIES – PROBLEM CORRECTION SYSTEM

The Contractor shall receive, track and resolve Problem Statements, and maintain a Problem Correction System (PCS). The Contractor's PCS and reporting shall be fully defined and documented in the Quality Assurance Plan and the Contractor's Policy and Procedure Manual. The Contractor shall:

1. Develop and maintain the PCS in an on-line database (e.g., ACCESS).

2. Utilize the PCS as the sole means of identifying and tracking problems identified by either State, Contractor, Managed Care Plan (MCP) staff, or any other entities as defined by the State in response to problems related to HCO operations. The Contractor shall track all problem statements received using the PCS. The Contractor shall ensure all problem statement processing time frames are met as specified in this section.

3. Maintain the PCS tracking/reporting system that shall be used as a tool to document the status of all problem statements to final resolution. This system shall generate PCS status reports.

4. Update the PCS within one business day of every action performed (e.g., IR, CAP, or CN submitted to the Department).

5. Correct all deficiencies identified through the PCS.

6. Ensure all documentation in the PCS is written to facilitate the interpretation of the documentation by an individual without technical expertise in computer operations.

7. Ensure all problem statements contain, at a minimum, all elements used in the State-approved Problem Statement form.

8. Ensure all forms, documents, and report formats utilized by the Contractor that pertain to the PCS have been reviewed and approved by the State prior to use.

9. Provide a diskette or transmit online to the State, due by the first business day of each week, of the prior end-of-week version of the PCS on-line database.

10. Maintain all hard copy documentation relating to problem statements (e.g., Problem Statement, Interim Response (IR), Corrective Action Plan (CAP), Closure Notice (CN), research, and testing documentation) at the Contractor's location. The Contractor shall maintain all such documentation for the duration of the contract, make it available to the State upon request, and turn it over to the State upon contract termination.

The State retains the authority to identify Problem Statements that require expeditious processing by the Contractor. The Contractor shall resolve these Problem Statements within 30 business days, with a CN submitted to the State within five business days of resolution. The State shall designate no more than 30 Problem Statements as requiring expeditious processing per year.

At the discretion of the State, an extension to any time frame indicated in the PCS may be granted on a request-by-request basis. The Contractor shall submit a written request to the State which, at a minimum, documents the work performed to date, the reason such an extension is necessary, and the targeted completion date.

3.7.3.1 Problem Correction System Procedures

The Contractor shall design a system, operated by the Quality Assurance Unit, to receive, process, track, and report on all Problem Statements issued by the State, Contractor, Managed Care Plan staff, and other entities as defined by the State. Various State staff shall have on-line inquiry capability to the PCS, but update capability shall be strictly limited to Contractor staff. The PCS shall meet all processing requirements and follow the processing steps in the order listed below.

1. Problem Statements

   Problem Statements are written to provide the Contractor with the identification of a potential problem, along with supportive data to initiate evaluation and resolution of each problem within the Contractor's operation. Problem Statements shall be submitted to the Contractor on the State-approved "Health Care Options Problem Statement" form within 24 hours of identification of a problem or incident.

   a. The Contractor shall assign a unique identification number to each Problem Statement.

   b. The Contractor shall assign a priority to each Problem Statement and have the flexibility to adjust the priority at any time, including Problem Statements already in the system. The three different priorities are:

      - A Urgent priority shall be assigned to issues that need to be resolved immediately and shall expedite a resolution.

      - A High Priority shall be assigned to issues that are less urgent, but still require attention to ensure processes are operating as designed and accurate information is provided.

      - A Medium Priority shall be assigned to issues that are related to diskette hard copy of health plan forms and issues related to the system that shall require a moderate amount of time to resolve.

      The State reserves the right to change any priority classification assigned by the Contractor.

   c. The Contractor shall input all Problem Statements into the on-line PCS database and concurrently submit copies of all

Problem Statements to the State within two business days of identification of any and all problems.

d. The Contractor shall confirm receipt of all Problem Statements with the originator, within two business days.

2. Interim Response (IR)

IRs provide a preliminary analysis, estimated amount of time required for completion, and an identification of where the problem exists within the HCO operations system.

a. The Contractor shall prepare an IR and forward it to the State for approval within five to ten business days from receipt of the Problem Statement. For those Problem Statements assigned an urgent priority, the Contractor shall have five business days from receipt of the Problem Statement to forward the IR to the State. For Problem Statements assigned a high priority or medium priority, the Contractor shall have 10 business days from receipt of Problem Statement to forward Interim Response to the State. The State shall have the sole authority to approve/disapprove the IR.

b. The Contractor shall provide the originator with an IR within five to ten business days from receipt of the Problem Statement. For those Problem Statements assigned an urgent priority, the Contractor shall have five business days from receipt of the Problem Statement to provide the originator with an IR. For Problem Statements assigned a medium priority, the Contractor shall have 10 business days from receipt of Problem Statement to forward Interim Response to the State.

c. An IR shall be waived if the CAP or CN is submitted within ten business days from receipt of the Problem Statement. For Problem Statements assigned an urgent priority, an IR shall be waived if the CAP or CN is submitted within five business days from receipt of the Problem Statement.

d. An IR shall provide at a minimum, but shall not be limited to: the Problem Statement number; the name of the individual or group assigned the problem for resolution; a summary of the stated problem; identification of preliminary findings, including programs which are affected and where the problem exists within the system or operation; and an estimate of time required for completion.

e. The Contractor shall prepare an IR by completing the State-approved "Problem Statement Response" form and checking the "IR" box.

f. Upon completion of an IR, the Contractor shall update the PCS within one business day.

g. The State may disapprove or request modification to an IR.

h. If an IR is disapproved by the State, the Contractor shall have five business days to correct the deficiency and resubmit the revised IR documentation to the State for approval.

3. Corrective Action Plan (CAP)

A CAP provides a complete analysis of the problem and identifies the actions and time frames necessary to correct the problem.

a. The Contractor shall prepare a CAP and forward it to the State for approval within 15 to 20 business days from receipt of the PS. For those Problem Statements assigned an urgent priority, the Contractor shall have 15 business days from receipt of the Problem Statement to forward the CAP to the State. For Problem Statements assigned a high priority or medium priority, the Contractor shall have 20 business days from receipt of Problem Statement to forward the CAP to the State.

b. A CAP shall be waived if a Closure Notice (CN) is submitted within 20 business days from receipt of the Problem Statement. For those Problem Statements assigned an urgent priority, a CAP shall be waived if a CN is submitted within 15 business days from receipt of the Problem Statement. For Problem Statements assigned a high priority or medium priority, the Contractor shall have 20 business days from receipt of Problem Statement to forward the CAP to the State.

c. A CAP shall provide at a minimum, but shall not be limited to: the Problem Statement number; the name of the individual or group assigned the problem for resolution; a summary of the stated problem; a comprehensive description of findings, including programs which are affected and where the problem exists within the system or operation; a description of how the Contractor intends to correct the error or eliminate the error pattern or deficiency; and an estimated date of correction.

d. The Contractor shall prepare a CAP by completing the State approved "Problem Statement Response" form and checking the "CAP" box.

e. Upon completion of a CAP, the Contractor shall update the PCS within one business day.

f. The State may disapprove or request modification to a CAP.

g. If the State disapproves a CAP, the Contractor shall have five business days to correct the deficiency and resubmit the revised CAP to the State for approval.

4. Closure Notice (CN)

A CN confirms correction of a problem or otherwise recommends closure of the problem statement.

a. The Contractor shall prepare a CN and forward it to the State and the originator within 30 business days from the Contractor's submission of the IR or five business days after the estimated completion date in the State's approved CAP. The State shall have sole authority to approve/disapprove the CAP.

b. The Contractor shall provide the originator with a CN within 30 business days from the Contractor's submission of the IR or five business days after the estimated completion date in the State's approved CAP.

c. A CN shall provide at a minimum, but shall not be limited to, the following: the Problem Statement number; a summary of the stated problem; identification of the source of the problem; a description of the modification(s) made to correct the problem; documentation showing quantifiable results, along with documentation of system testing; and the date the modification(s) was installed into production status.

d. A CN shall also include any system documentation or procedure/training manuals that need to be updated or created to document the modification(s).

e. The Contractor shall prepare a CN by completing the State-approved "Problem Statement Response" form and checking the "CN" box. All CN supporting documentation must be attached.

f. If the Contractor determines the problem was not an issue that could be addressed by the Contractor, or if the problem was immediately corrected (i.e., beneficiary enrollment problem was corrected), the Contractor shall prepare a CN by submitting a brief explanation on the Health Care Options Problem Statement form. All CN supporting documentation should be attached.

g. Upon completion of a CN, the Contractor shall update the PCS within one business day.

h. The State may disapprove or request modification to a CN.

i. If the State disapproves the CN, the Contractor shall have five business days to correct the deficiency and resubmit the revised CN to the State for approval.

j. The closure date on all approved-for-closure Problem Statements shall be the date the State signs the HCO Problem Statement Approval/Disapproval form.

3.7.4 QUALTIY ASSURANCE REPORTING/DELIVERABLES

3.7.4.1 Monthly Qualtiy Assurance Performance Reports

The Contractor shall prepare and submit Monthly Quality Assurance Performance Reports, which shall include reports identifying process-oriented error trends and proposed process improvement recommendations. The reports shall be based upon data collected from, but not limited to, problem statement closure notices, monthly quality assurance performance sampling, and internal audits.

The reports shall contain at a minimum:

1. Ongoing trend analysis graphs identifying frequency of errors for the previous month's reporting period, plus a cumulative analysis of errors from the beginning of operations.

2. Identification of the specific processes within the Contractor's operation that contributed prominently to the error's occurrence.

3. Identification of all the adverse impacts as a result of the defective process, and the number of resulting errors.

4. Recommendation of process and policy changes that would reduce the recurrence of errors and detail what would be involved to complete the change.

   When necessary, the State shall provide, in writing, policy instruction, change requests, Problem Statements (PSs), or Change Orders to notify the Contractor of changes that must be made to the Contractor's system based upon State review and approval of Contractor process and policy change recommendations.

3.7.4.2 Problem Correction System Status Reports

The Contractor shall forward to the State weekly PCS status reports, due by the third business day of each week following the report week. The Contractor shall also forward to the State monthly PCS status reports, due by the tenth business day of each month for the previous month's reporting. An exception is the monthly Problem Statement Disposition Report, which must be mailed to the various health and dental plans and the State by the fifth business day of each month for the previous report month.

The PCS status reports shall serve as a joint tracking system; therefore the State shall retain the right to approve/disapprove the information provided by the Contractor on a report-by-report basis. When information has been disapproved, the Contractor shall have five State business days to revise and resubmit the PCS status reports to the State.

3.7.4.3 Deliverables

In addition to deliverables already specified in this Section, the Contractor shall also submit a monthly written report on Problem Statement timeliness, identifying the status of every unresolved Problem Statement that has exceeded the Problem Statement time frames as specified in this Section. The report shall provide, at a minimum: a listing of each Problem Statement exceeding the processing time frame(s); a statement of why each Problem Statement has exceeded the time frame(s); estimate of staff resources required to resolve each Problem Statement; and, when the required Problem Statement deliverable shall be submitted.

3.8 SECURITY AND CONFIDENTIALITY REQUIREMENTS

3.8.1 OVERVIEW

This Section describes the requirement for the Security and Confidentiality Plan and Procedures, which shall be developed and submitted to the State and implemented by the Contractor by the contract effective date.

3.8.2 CONTRACTOR RESPONSIBILITIES-SECURITY AND CONFIDENTIALITY

1. The Contractor shall comply with all security and confidentiality requirements specified in the contract from the effective date of the contract through the end of the contract.

    a. The Contractor shall ensure that the contents of this section are included in the standard language of any subcontract entered into to perform work arising from or related to this contract.

    b. Upon request from the Contracting Officer, the Contractor shall submit documentation acceptable to the State to demonstrate compliance with security and confidentiality requirements and shall certify, in writing, that all requirements of this section have been and shall continue to be met throughout the life of the contract.

2. The Contractor shall permit authorized State and federal representatives to access any HCO facility, subcontractor facility, equipment, and related materials covered by the contract. Such access shall be at the discretion of the Contracting Officer. Only authorized State representatives shall have 24 hour access to any HCO or subcontractor facility for the purpose of an unannounced inspection and monitoring.

3. The Contractor shall develop, implement, and maintain a State-approved Security and Confidentiality Plan and Procedures for all Contractor employees and subcontractor staff.

    a. All Contractor facilities associated with this contract shall be addressed in the Security Plan. Facilities shall include, but are not limited to, the equipment room; software and data libraries; supervisor area; job entry area; enrollment and disenrollment form processing area; mail room; computer terminals; telephone service center room; junction boxes; and HCO presentation sites. Facilities shall also include transportation and data holding resources used by the Contractor throughout the term of the contract and the facilities that handle both enrollment and disenrollment information.

    b. The Contractor shall establish a security and confidentiality training program as part of the Security and Confidentiality Plan and Procedures specifically designed for all levels of Contractor staff.

c. The Contractor shall provide all security and confidentiality procedures or related documentation to the State within one business day after receipt of a request from the Contracting Officer or his/her designee. All procedures required in this section shall be developed and formally submitted to the State for review and written approval prior to implementation.

4. The Contractor shall limit access to beneficiary-identifying information to persons or agencies that require the information in order to perform their duties in accordance with the contract. Any other party shall be granted access to confidential information only after complying with the requirements of State and Federal laws and regulations pertaining to such access. The State shall have absolute authority to determine if and when any other party has properly obtained the right to have access to this confidential information.

   a. The Contractor shall ensure the confidentiality of beneficiary information.

   b. The Contractor shall ensure that all information, records, and data collected in connection with this contract are protected from unauthorized disclosures.

   c. The Security and Confidentiality Plan and Procedures shall contain a State-approved script to ensure confidentiality guidelines are followed whenever parties other than the beneficiary are accessing information.

5. All of the Contractor's facilities shall be secured so that only authorized persons, including persons designated by the Contracting Officer, are permitted entry into the facility and that such persons are restricted to areas where they are permitted access. Access control requirements shall include, but not be limited to:

   a. Contractor staff shall be familiar with and adhere to the written security policy.

   b. Facility entry and control points shall be guarded or locked at all times. Control points shall be established for each of the following: entrances to the processing facility where both enrollments and disenrollments are processed; service entrances; loading platforms; garage entrances; equipment/facilities; and secondary entrances.

   c. The Contractor's processing facility shall be a secured building, providing segregated areas that contain confidential information.

There shall be no access to unauthorized personnel in these segregated areas.

d. The Contractor shall have available and furnish to the State as a part of the Security and Confidentiality Plan and Procedures, a current list of all authorized staff and their levels of access. Upon change of duties or termination of Contractor staff from work under or arising from this contract, access authority for that staff member shall be removed.

e. The Contractor shall log the entry and exit of visitors and messengers by visitor name, agency represented, date and time of arrival and departure, and name of individual to whom visit is made. Identification credentials of all visitors shall be checked. Visitors shall be badged and escorted to their destination by a Contractor employee.

f. Passwords shall be required to access MEDS and any other system needed to perform HCO functions.

g. The Contractor shall develop and maintain procedures for the handling, packaging, and transportation of confidential information or resources. The procedures shall ensure against unauthorized access. These procedures, including all updates, shall be submitted to and approved by the State.

h. The State server room shall be secured from entry by the Contractor staff.

i. The equipment room/facilities shall be locked at all times.

j. During non-business hours, the facility shall be protected against intrusion with an appropriate surveillance alarm extended to a staffed monitoring center.

k. The Contractor shall establish and maintain internal security procedures and implement safeguards to protect against possible collusion between Contractor employees and plan providers or others.

3.9 DISASTER PREVENTION

3.9.1 OVERVIEW

The Contractor shall provide measures and means to ensure prompt detection, reporting to appropriate authorities, emergency handling of fire, water intrusion, explosion, or any other disaster. These requirements are applicable to the Contractor's sub-contractors as well.

3.9.2 CONTRACTOR RESPONSIBILITIES-DISASTER PREVENTION

3.9.2.1 Fire Prevention, Detection, and Suppression

Contractor facilities shall comply with existing local, State, and federal fire safety regulations. The fire detection and alarm system power supply shall be uninterruptible with a twenty-four hour battery pack.

All doors that are required to remain closed and locked and that serve as points of exit in the event of emergency shall be equipped with "panic bar" door releases or equivalent mechanisms.

Procedures dealing with fire safety, evacuation of the facilities and regular fire drills shall be developed by the Contractor and submitted to the State for approval as part of the Security and Confidentiality Plan and Procedures. These procedures shall include, but are not limited to, planning for the evacuation of disabled staff; for the assignment and training of "fire wardens" for each section who can be easily identified by employees; for the designation of meeting places for staff after evacuation; for the posting of exit signs and "evacuation route" maps throughout the facilities; and for the clearing of personnel from all areas, including rest and lounge rooms. Both Contractor and State staff shall be trained in and familiar with these procedures.

3.9.2.2 Facility Environment

The Contractor facilities shall comply with State and local building codes and Americans with Disabilities Act (ADA) standards. Facilities shall comply with equipment vendor requirements for temperature, humidity, and cleanliness. Any source of potential computer equipment malfunction shall be corrected immediately, whether identified by the State or Contractor.

3.9.2.3 Threats

The Contractor shall protect the staff and facilities from danger stemming from bomb threats and civil disturbances. The Contractor shall develop procedures dealing with these eventualities and shall submit such procedures to the State as part of the Security and Confidentiality Plan and Procedures.

All Contractor and State staff shall have access to, and to be familiar with, bomb threat procedures and procedures dealing with civil disturbances.

3.9.2.4 Disclosure

Only authorized persons shall be permitted to access:

a. Sensitive or confidential data, whether hard copy or electronic.

b. Software programs and system documentation, including procedure manuals.

c. Computer room, disk and tape libraries, vaults.

The Security Plan shall address procedures for dealing with four potential categories of threats:

a. Accidental disclosure, modification or destruction because of hardware error, software error, human error, or a combination of these.

b. Casual access, resulting in unauthorized disclosure, modification, or destruction.

c. Premeditated criminal acts.

d. Natural disaster.

Sensitive data shall be handled and stored in such a manner as to preclude unauthorized disclosure. It shall be stored in secured archives or, if destruction is necessary, it shall be destroyed appropriately. The integrity of sensitive data shall be protected from unauthorized disclosure at all times, including during transit.

3.9.2.5 Back-up and Recovery

The Contractor shall develop a Contingency Plan and Procedures, as a subset of the Security Plan, that provides for adequate back-up and recovery for all operations, both manual and automated, including, but not limited to, all functions required to meet the back-up and recovery time frames of this subsection. The Contingency Plan shall include at a minimum:

a. Back-up Requirements

1) Data files plus file log (including location of files)

2) Application and operating system software libraries, including related documentation.

3) Procedure and user manuals.

4) Hardware.

5) Manual/Automated processes.

6) Personnel.

7) Communication Protocol

8) Critical Functions Identification

b. Back-up Facility and Resources

The Contractor shall allocate specific resources for an adequate and specifically identified back-up facility where HCO operations can be continued in the event of disaster. The back-up facility and resources shall be sufficient to comply with contract requirements and shall be sufficient to deal successfully with both small and large disasters.

The back-up facility shall, at a minimum, provide for:

1) Adequate hardware/software compatibility between the back-up facility and the HCO operations facility.

2) Availability of adequate computer resources including computer time and all necessary peripherals for the entire HCO operations.

3) Availability of adequate telephone resources including telephone lines and all necessary peripherals for the Customer Assistance – telephone service function.

4) Availability of adequate off-site data entry services.

5) Availability of alternative space for staff and equipment in case the main facility is destroyed.

6) Switching of HCO LANs/terminals to back-up facility.

7) Availability of adequate staff required for all HCO operations.

8) Access to all resources mentioned in the Back-up Requirements defined above, e.g. data files, software, etc.

9) Ability to shift operations to the back-up facility within time frames and priorities that are acceptable to the State.

The back-up facility shall be available for transfer for the full HCO operation within 24 hours after the main facilities are unable to perform key HCO operations. Customer Assistance – telephone service and processing emergency enrollments/disenrollments or medical exemptions to MEDS shall be resumed within three State business days. Full HCO operations shall be resumed within seven calendar days.

c. Recovery

The Contingency Plan and Procedures shall provide for recovery from a minor malfunction to and including a major disaster. The Contractor shall:

1) Identify staff to be contacted in the event of disaster. The assigned staff shall be thoroughly familiar with recovery procedures.

2) Demonstrate ability to recover from State-defined disaster situations on at least an annual basis.

3) If the recovery includes the use of a third party, include in the contingency plan a method to assure the availability of all necessary operations. The plan must include guarantees that in the event of a disaster, the State shall not be put in line for services from a third party.

The Contingency Plan and Procedures shall be included with the Security Plan.

3.10 HEALTH CARE OPTIONS SYSTEM OPERATIONS, MAINTENANCE AND CHANGE REQUIREMENTS

3.10.1 OVERVIEW

The California Medi-Cal Managed Care Program is a very sensitive and complex program with several different health care plan models serving large beneficiary and enrollment populations. Due to the size and complexity of the program, the HCO process shall require a dependable, tested system(s) that

shall be easily operated, maintained and modified. Any system proposed for operation should be table-driven to the maximum extent possible to allow for timely changes and ease of operation.

The Contractor shall provide a system that the State shall purchase or lease at the end of this contract . This system shall be comliant with the standards set forth in the Health Insurance Portability and Accountability Act.

It is at the Contractor's discretion to propose a mainframe system, client server system, or a combination of these. The system must be programmed in a nationally recognized programming language (e.g., mainframe: COBOL; client server: C++, Visual Basic). There must be a complete set of documentation, including but not limited to hardware, software, and operating system specifications, application documentation (e.g. flow charts, Warnier/Orr diagrams, or any other State approved document) and any other pertinent information that would be needed to operate the proposed system as a whole. The system must be expandable and able to handle the transaction volumes described elsewhere in this document.

The Contractor may propose a proprietary system(s) the State shall not own at the end of the contract. However in this event, the State shall own all data, data files and tables, documentation, program modifications made, and policy, operations and procedure manuals developed or used during this contract.

3.10.2 CONTRACTOR RESPONSIBILITIES – HCO SYSTEM

3.10.2.1 HCO System

The Contractor shall provide, operate and maintain a Health Care Options (HCO) processing system, including any telecommunication systems, throughout the term of the contract, which shall at a minimum:

1. Provide accurate, complete and current information on the health care plan enrollment status and enrollment history for new, ongoing and past managed care eligible Medi-Cal beneficiaries.

2. Provide information on health care plans including geographic area served, available plan capacity, availability of primary care service site by ZIP code, and if the plan can accommodate the person's primary language.

3. Timely and accurately notify, enroll and disenroll beneficiaries into and out of health care plans in accordance with State HCO policies and contract requirements.

4. Allow for the enrollment of individual beneficiaries into up to five health plans at the same time, such as a separate medical, dental, vision and/or special health condition (i.e. California Children Services) health plan.

5. Develop and maintain a process to accurately assign beneficiaries who have failed to make a timely health care plan choice into an available plan(s) in accordance with State HCO policies and contract requirements.

6. Transmit and retrieve data files via a direct data communications link connected to the State's Host computer.

7. Develop and maintain a process to track and report on the elapsed processing time and the status of each beneficiary, transaction and other required documents to allow for an audit trail of activity and to report on activity cycle times.

8. Create on demand special beneficiary listings or files based on selection criteria provided by the State.

9. Have the ability to make mass beneficiary file updates and changes.

10. Identify and take appropriate action for date or period specific requirements such as annual beneficiary re-notification or end of medical exemptions.

11. When available, accept a beneficiary address containing an 11-digit Delivery Point Bar zip code.

12. Capture data sufficient for all reporting requirements and produce required reports.

13. Provide other management reports on an ad hoc basis or via file download in a format to be determined by the State.

14. Provide the State with the ability to develop and generate ad hoc reports directly.

15. Provide the State on-line "read-only" access to various system files and reports.

16. Allow for efficient and timely system updates, modifications and maintenance.

17. Support all HCO functions and activities.

18. Maintain security and confidentiality.

19. Provide system backup and disaster recovery.

3.10.2.2 System Availability

1. All applications necessary to support Customer Assistance, transaction processing, ad hoc reports and State oversight shall be available nine hours a day, from 8 a.m. to 5 p.m. Pacific time, Monday through Friday (except State holidays). Normal systems maintenance shall not be scheduled or run during the required system availability time.

2. System downtime for the applications necessary to support Customer Assistance, transaction processing, ad hoc reports or State oversight shall not exceed one-half hour per week during the required system availability time on average for a month.

3. Within one hour of each incident of downtime occurring within the system availability requirements, the Contractor shall notify the State via e-mail and phone call. The Contracting Office shall provide the Contractor the list of names and e-mail addresses to contact.

4. The Contractor shall provide the State a monthly report due by the fifth business day of the following month of all downtime occurring within the system availability requirements. This report shall contain the date, time, number of minutes of duration, cause, and preventative resolution.

3.10.2.3 HCO System Response Time In Support of Customer Assistance

1. Ninety-five percent of system inquiries shall be processed within three seconds. The three seconds begin from the time the inquiry is entered (the “enter” button is pressed) until all data is displayed on the screen.

2. The Contractor shall monitor and report average terminal response time monthly by the fifth business day of the following month.

3.10.2.4 Change Requirements

During the term of this contract, the program administered in this contract shall be dynamic, requiring changes and updates to the HCO system(s) and the Contractor’s operations. A high emphasis should be placed on the installation and maintenance of a system which has the capability to

implement such changes and updates in an orderly, timely, and accurate manner.

The State recognizes that the scope and complexity of changes shall vary over the life of the contract. The State requires adequate assurances that a given change has been correctly applied. State approval of change documents and related monitoring efforts shall reflect this policy.

The Contractor shall update any documentation to automated or manual systems resulting from H-OILs, Problem Statements, System Development Notices, and Change Orders.

1. State-Initiated Changes

   The Contracting Officer may at any time, within the general scope of this contract, by written notice, require changes to the HCO system and related operations. The State shall utilize a formalized process to notify the Contractor on an ongoing basis and in a timely manner of changes to be made to the HCO system(s) and related operations. This process shall make use of the following four documents:

   a. HCO Operating Instruction Letter (H-OIL) – This document shall be utilized to notify the Contractor of new, modified, updated and/or clarifications made to the HCO policies.

   b. Problem Statements – This document identifies operational problems found in the system by the state, the health plans or the Contractor, and shall in some cases generate corrections/modifications to the HCO system(s).

   c. System Development Notices (SDN) – This document shall be utilized to notify the Contractor of system changes that require programming alternations to one or more of the HCO systems.

   d. Change Order – This document alters work to be performed by the Contractor.

   The Contractor shall track and report monthly, by the fifth business day of the following month of State change notification, the status of H-OILs, SDNs, Problem Statements, and Change Orders.

2. Change Implementation – Policy Changes

   The Contractor shall make any changes necessary to implement managed care policy changes identified in H-OILs to the HCO

system(s) files, tables, programs, applications, or operations following listed changes:

a. Adding, deleting, and/or modifying information from the monthly Project Control Table file including participating county codes, health plan codes, mandatory or non-mandatory beneficiary aid codes, and/or covered ZIP codes,

b. Adjustments to the beneficiary assignment algorithm logic, plan minimum/maximum beneficiary levels, and health care plan effective dates.

c. Adding, deleting, and/or modifying medical exemption and/or emergency or non-emergency disenrollment reason and status codes.

d. Adding, deleting, and/or modifying MEDS HCO transaction log error codes, and/or beneficiary health care plan status codes.

e. Creation of new files and/or changes to existing files as a result of a change in the MEDS file layout.

The Contractor shall update any documentation to automated or manual systems resulting from H-OILs. Unless otherwise specified by the Contracting Officer, the system files, tables and applications updates required in a H-OIL shall be placed in the production system within three business days of the date of the H-OIL. In addition, the State may request up to five emergency H-OIL updates per month. The Contractor shall implement the emergency H-OIL updates within one business day of the date of the H-OIL. All changes shall be considered normal operational changes, covered under the fixed price cost of this contract.

In addition to any testing/verification/change control process requirements imposed by HCO Operations, Maintenance, and Change Requirements the State reserves the right to require that a second verification be performed prior to any new or updated data being used in production. Someone shall perform this second verification other than the individual(s) who initially input the data. Results of this second verification shall be documented in a log or report and available to the State monitoring staff.

3. Change Implementation – Contract Compliance

The Contractor shall make any changes or necessary modifications to bring the Contractor into compliance with existing contract requirements or responsibilities resulting from:

a. Contractor- and State-initiated Problem Statements or Problem Statements due to system emergency fixes,

b. System reviews due to operations errors,

c. Maintenance/upgrades of the computer operating systems or system utilities; installation and maintenance of licensed proprietary products, or data base systems; and maintenance or operation of equipment, at both the central and field offices.

These changes or modifications are considered a Contractor responsibility covered under the fixed price cost of this contract. In addition, time needed to support normal system processing, on-going job set up and/or to coordinate all backup or recovery procedures are considered a Contractor responsibility covered under the fixed price cost of this contract.

4. Change Implementation – Other Needs

All other changes and/or modification to the HCO system(s) required by the Contracting Officer as a result of new or expanding program needs or requirements shall be reimbursed at the rates bid by the Contractor for CSRG staff. The time for the design, development and installation of the required changes shall be negotiated by the Contractor and the Contracting Officer.

5. Contractor-Initiated System Upgrades

During the term of this contract, it is assumed the Contractor shall implement updates or new generation versions of HCO programs or applications and other operating systems software. All activities associated with system upgrades and/or maintenance including, but not limited to development and installation of these changes shall be at the Contractor's cost. At a minimum, the Contractor shall follow these procedures when updating or refreshing systems, programs or applications:

a. Notify the State in writing at least two weeks prior to implementation of the change. This notification shall contain a description of the change and how the proposed change will impact the current system. The notification shall also include a

description of how the change shall be tested, including test conditions and criteria.

b. Fully test the change in our HCO system and environment prior to implementation into production. The Contractor must share the test outcomes with the State prior to implementation.

c. Certify the accurate implementation of the change and take responsibility for any and all changes or corrections necessary to either manual or automated HCO system(s) impacted as a result of the Contractor-initiated change.

d. Correct any problems and reconstruct or re-implement any programs or applications timely without any interference with other contract requirements or standards resulting from implementation of these changes.

6. Change Control

The Contractor shall establish a convention to track changes or revisions to the HCO system. This convention shall allow an audit trail to exist for all revisions. The revision structure shall consist of:

a. Control number – relates to an change control number.

b. Revision date – effective date of the change.

c. Implementation date – date of the implementation

d. Revision Indicator – use to identify the revision sequence on each page of the documentation.

3.10.2.4.1 Contractor's Obligation to Implement

The Contractor shall be required to make changes mandated by the Contracting Officer. In the case of mandated changes in policy, regulations, statutes, or judicial interpretation, the Contracting Officer may direct the Contractor to immediately begin implementation of any change. In the case of SDNs or Change Orders except as limited by review of State and Federal control agencies, if so directed by the Contracting Officer, the Contractor shall be obligated to implement the required changes with concurrent negotiations of either System Group (SG) hours or price revisions taking place. In those cases, SG work shall commence immediately, prior to the Contractor's response to the SDN.

3.10.3 System Support

3.10.3.1 Systems Group (SG)

The Contractor shall establish and maintain a local SG capable and authorized to maintain and modify the HCO system(s). The SG shall be co-located in the same facility as the HCO Operations staff. SG positions identified in the Contractor's Technical Proposal as dedicated to this contract shall be filled during the term of this contract. The only exception to the location requirements defined above will be during the System Development Notice process where some of the work, as described in the paragraph below, may be done by Contractor staff located at another site.

This SG shall consist of a Systems Group Manager and a sufficient number of, but not limited to, Systems Analysts, Systems Programmers, Hardware/Telecommunication specialists, Technical Writers, and Computer Operators to meet all contract requirements. The Contractor shall also provide adequate clerical staff to meet and perform clerical and word processing support needs of the SG as part of the fixed hourly rate for SG Staff.

1. System Group Responsibilities

   The Contractor shall establish and utilize the SG to:

   a. Operate and maintain the HCO data processing and telecommunication systems, including but not limited to, system(s) programs and applications, the computer hardware and cables, automated interfaces with all State computers, any local area networks, and the telecommunication equipment and cables.

   b. Maintain the interface with MEDS to ensure information is processed efficiently and accurately,

   c. Make State-directed policy updates and modifications to the HCO system application programs, tables and file structures,

   d. Perform necessary system related Problem Statement research and prepare Corrective Action Plans (CAPs) and implement Department approved CAPs and generate correction notices that pertain to application programs,

   e. Maintain and refresh the HCO system test environment,

f. Design, develop and install State-initiated changes to the HCO system, applications, or programs.

g. Accept and support all newly implemented systems or modifications of existing programs.

h. Provide programming support for the State's ad hoc report requests.

i. Develop and generate management reports.

j. Develop and maintain a process to allow the State to create and generate their own ad hoc reports from the HCO system(s).

k. Develop and maintain HCO system documentation

l. Develop and maintain Telephone system documentation.

m. Develop and maintain Mail-house system documentation.

n. Provide consultation, assistance or user liaison services to the State related to the HCO process, computer systems and applications, automated interfaces, and telecommunication systems.

2. Additional Systems Group Staff

In addition to the required SG staff, the State may authorize up to five additional local SG staff perform special projects. These staff shall be supervised by the SG Manager but shall work full-time only on State-requested assignments and services. These additional staff may not be used to perform any contractually required work, provide any contractually required services or work to bring the Contractor into compliance with existing contract requirements.

The State shall provide a description of the duties, range of salary, responsibilities, length of commitment, and qualifications required of each additional SG position. The State has the right to participate in the selection and approval of each candidate prior to commitment to hire. The State reserves the right to require the Contractor to fill each authorized positions within sixty (60) days of written notice or to eliminate the position early for cause within thirty (30) days after the Contractor's receipt of the State's written notice. In this situation, for cause is defined as 1) specific additional staff found performing contractually required work, providing contractually required services or work to bring the Contractor into compliance with existing contract

requirements or 2) specific additional staff found to not meet qualifications as required.

3. System Group Support of Monitoring

To assist the State in monitoring and the oversight of the Contractor's performance and contract compliance, the Contractor shall:

a. Provide State staff with system training and documentation on the design, applications, maintenance and modification of the system.

b. Provide in-house training on the system(s) design (including any proprietary software/systems), applications, operations, maintenance processes and system documentation for up to Twenty-five State staff annually. The Department shall agree to not share proprietary software/systems specifications with other potential competitors or contractors.

c. Maintain at the Contractor's local site a current version of all non-proprietary system code, general system design, system functional design, technical system design, data element dictionary, files and tables, operating instructions and other related documentation. All documentation shall be prepared in a format that facilitates updating.

1) General System Design shall contain a pictorial diagram depicting the overall HCO system flow, each subsystem, and every subsystem module defined. Each diagram shall have a narrative that describes the tasks that are to be performed and the related inputs and outputs shown.

2) System functional design shall contain: List of input files and data items to be used; data item descriptions; step-by-step process definitions, for both computer and manual processes, including a program level design; definitions of report contents at a data item level; descriptions of any other output; data flow diagrams, process, models, etc., to help users understand how the system/application works; and timing and frequency of operation of the system.

3) Technical system design shall contain: Overall system design showing each individual program and the inputs and outputs for each; specifications of sufficient detail including logic diagrams, general system design program

flowcharts, job/file flowcharts, and/or program logic flowcharts; and file layouts for all input and output files for each individual program.

d. Develop and maintain through the life of this contract an independent system test environment to be used in the SDN system test phase, file and tables update verification, problem statement research and testing, routine monitoring, and system troubleshooting. Testing shall be done in a separate environment from Operations but must duplicate the functionality of the production environment. The Test environment must be capable of handling files of various volume and variety. Reference files in test must be refreshed routinely.

e. Develop and maintain through the life of this contract a Structured Change Control Process to be used to record and document all changes and updates to the HCO system (s).

4. System Development Notice (SDN)

It is anticipated the State shall require some changes to the Contractor's application software during the term of this contract. A listing of system changes initiated during the current contract can be found in the OMCP Data Library.

a. State Notice

For those changes that require a change to the Contractor's application software, the Contracting Officer shall issue an SDN document to the Contractor. The SDN shall define the change, identify the general functional requirements of the change, the priority of the change, whether phases and deliverables shall be consolidated, identify prior authorized hours for the Contractor to complete the "Acknowledgement of SDN Request", types of acceptance test requirements, required walkthroughs, and requested operational date.

b. State System Development Phase Responsibilities

The State is primarily responsible for the following phases of the system development:

1) Project Definition and Analysis (PDA) Phase.

The initial PDA Phase involves identifying and confirming the need for a modification of the system, analyzing the

alternative means of implementing the change, and defining the method of change. Primary responsibility for the PDA Phase is the State's; however, SG management shall participate in discussions with the State regarding alternatives and their system impact. It is anticipated that these meetings shall take place on an informal and scheduled basis during the course of normal business.

2) General Functional Requirements (GFR) Phase.

The GFR Phase shall provide a general systems approach to the problem/solution. The GFR Phase includes a general description of the various objectives of the change/modification and the general and specific desired results/solution. This shall include:

a) A general description of the types of input information required by the system;

b) A description of the policy requirements;

c) A general description of the processing results required; and

d) A general description of the system output, outlining the format and use.

The GFR shall be provided to the Contractor through the SDN process. SG staff and management shall also participate in the GFR Phase.

3) User Acceptance Testing

The State may conduct comprehensive Acceptance Testing of manual and automated processes to ensure that the Contractor is adequately prepared for implementation of any system change affecting HCO operations.

c. Consolidated Deliverables

The State has the right to consolidate phases and deliverables, as appropriate, for each SDN. Therefore, when the State determines that a change to the system is simple and has limited system impact, the State shall have the flexibility to authorize a "short form" SDN. The "short form" could mean

shortening or combining the deliverable documentation. The SG manager, when analyzing and responding to the SDN, shall recommend if the SDN request merits an SDN "short form." If it has been determined, by the state, that a "short form" will or can be used, the Contractor shall include with the formal SDN response letter a "check-list" which identifies which phases/deliverables can be combined and which describes/substantiates the limited system impact.

d. Contractor Response

The Contractor shall have twenty business days from the date of receipt, or more if deemed necessary by the Contracting Officer, to respond to a SDN. The Contractor shall provide the State, in writing, with an "Acknowledgement of SDN Request" to include the following:

1) A description of how the impacted system is currently working and implementing existing policy.

2) How the requested change shall impact the current system.

3) Recommendation as to how the Contractor shall implement the requested change, to include at a minimum:

a) The initial estimated number of hours and cost for the change based on currently known requirements and an estimated implementation date of the requested change.

b) The staff the Contractor intends to use to make the change and their location

c.) A list, description and an estimate of cost to operational areas impacted by the change, e.g., new/modified edits, tables, files, screen changes, manual and automated operational changes, need for staff training, new/modified reports including information available to the health care plans, change in how transactions are reported, monthly reconciliation and daily eligibles file process, mailing process, assignment algorithm, system generated letters, etc.

d) A statement by the Contractor whether they believe this SDN will result in a request for a Change Order.

5. Approval to Proceed with SDN

Based on the information contained in the Contractor's "Acknowledgement of SDN Request", the Department may cancel the SDN or authorize the Contractor in writing to proceed with the SDN. If the requested change is a result of new or expanding program needs or requirements and is outside the contract scope, the approval to proceed shall contain the number of pre-approved design, development and implementation SG hours payable pursuant to Payment Provisions (Subsection 8.5.3).

6. Contractor System Development Phase Responsibilities

The Contractor shall have primary responsibility for all technical processes and products required for the three phases of system design, development and implementation:

- Phase I – specific functional design, work plan development, and definition/preparation of systems and acceptance test criteria;
- Phase II – technical system design, programming, testing, and education/training; and
- Phase III – implementation and post-implementation review.

The Contractor shall be required to provide walkthroughs on deliverables for all phases of system development, unless waived by the Contracting Officer. Deliverables for these walkthroughs shall be delivered no later than five State business days prior to the walkthrough. Implementation approval walkthroughs shall be held no less than one week prior to the scheduled operational date, unless prior State approval is granted. If draft deliverables are used, final deliverables must be delivered to the State within fifteen calendar days of the walkthrough approval.

The SG shall follow the three specified phases in designing, developing, and implementing a computer software system change. The Contractor shall submit for approval all required deliverables to the State at the completion of each phase. The OMCP Data Library contains sample formats for the Specific Functional Design (SFD) and Technical Systems Design (TSD). The three phases are described in the following three sections.

Certain development projects undertaken in this contract shall require the involvement of health care plans or other impacted parties in defining system requirements and testing. In those cases, the Contractor, in co-ordination with the State, shall involve health care plans/other impacted parties as necessary.

Each deliverable in each phase shall meet documentation requirements as defined in each phase. The Contractor shall provide an electronic file and a minimum of three hardcopies of each deliverable to the State for review and approval.

a. Phase I – System Design

All deliverables under this Phase shall be submitted to the State for review and approval, including the following:

1) Specific Functional Design (SFD)

Describe the design approach in a document from which the Contractor technical staff shall produce programming specifications.

Deliverables – An SFD document which shall contain:

a) A list of input files and data items to be used;

b) Data item descriptions;

c) Step-by-step process definitions, for both computer and manual processes, including a program level design;

d) Definitions of report contents at a data item level;

e) Description of any other output;

f) Data flow diagrams, process models, etc., to help users understand what is being done under this SDN;

g) Timing and frequency of operation of the system; and

h) Special considerations in developing the technical system design.

This document, once formally approved by the State, shall not be changed without State approval.

2) Work Plan Development

Develop a detailed estimate of hours and a detailed estimate of the dollars and staffing levels for each phase for the entire project.

Deliverable – A work plan for the entire project which at a minimum contains the following:

a) The tasks to be performed including a subdivision of the task into major subtasks (logical increments of work not to exceed forty staff hours or one week).

b) Personnel hours, personnel classifications required and other resources for each subtask summarized by major subtasks and tasks.

c) Methods the Contractor will use to control work performance.

d) Problems anticipated and contingencies developed

e) A schedule for the tasks in narrative form and a Gantt Chart or equivalent. The narrative and Gantt Chart shall identify deliverables and dates.

f) Tasks and final SDNs completion dates.

g) A plan for performing the post implementation review.

3) Test Plan

Develop a definition of general test criteria to be used for the change.

b. Phase II – System Design and Development

All deliverables under this Phase shall be submitted to the State for review and approval, including the following:

1) Technical System Design (TSD)

Produce program level specifications and an overall system design for use by programming and Operations staff in implementing the system. The overall design shall be based on the design given in the specific functional design, but shall contain more detail.

Deliverables – TSD document which shall contain:

a) Overall system design showing each individual program and the inputs and outputs for each;

b) Specifications of sufficient detail including logic diagrams to allow the programmer to begin developing programming code. This may include general system design program flowcharts; job/file flowcharts, and/or program logic flowcharts, and/or Warnier/Orr diagrams, etc.;

c) File layouts for all input and output files for each individual program; and

d) Detailed test matrix of all known test conditions/criteria developed by the Contractor and State staff to be used for stand-alone, parallel, and volume testing.

The TSD is a dynamic document and shall be updated to reflect changes as they occur.

2. Programming

Produce executable instructions based on the specifications developed in the TSD. In this step, each program specification shall be converted into executable instructions and modified until these instructions are syntactically and logically correct.

3. Testing

Produce individual test programs and total test systems that shall assure the results desired for the system change. Testing shall be done in the environment described above.

The individual programs shall be tested to ensure that the information is processed correctly. Individual program interaction tests and full system tests shall be performed respectively. The State and SG shall have access to the system-testing environment. The Contractor's manual control procedures and the State's user procedures shall be developed and tested.

Provide support for the State to jointly or independently acceptance-test the change. The testing activities shall follow the outline provided in the Contractor's work plan, or the Contractor shall provide an explanation as to why there was a deviation from the proposed plan.

Deliverables – Test result review document that shall contain:

a) Test plan;

b) Summary of results;

c) Run logs;

d) Input and output file data that is formatted for easy review;

e) Test reports, including before and after results;

f) File comparison generated as result of parallel testing; and

g) All backup documentation pertaining to each condition tested shall appear directly following the page that describes the specific test condition.

4. Education/Training

Prepare a comprehensive training plan for all personnel affected by system modifications including health care plans, State staff, and Contractor staff. User personnel shall be trained in the system procedures and controls in preparation for the system change. The SG shall coordinate with Contractor training staff to develop or modify training syllabi, desk references and other training materials.

If the Contractor determines that Education/Training is not needed, justification must be provided to the State.

Deliverables:

a) User procedure manual/manual updates, general and detailed design documentation, etc.

b) Detailed user training plan.

c) System training guides and materials.

d) Training of user personnel.

e) Health Care Plan materials – To prepare the health care plans regarding modification to the system, if necessary.

c. Phase III – System Implementation

All deliverables under this phase, except program code, shall be submitted to the State for review and approval.

1. Implementation

In this step, the changes shall be transferred into production status, modifying the existing system. The Contractor shall notify the State three days before the change is scheduled and the morning after the implementation has occurred. The Contractor shall monitor the change through the completion of one monthly cycle. Any new procedures shall also be put into place at this time.

Deliverables:

a) Complete system detail design documentation standards to include:

- Input and output file description;
- report layouts;
- program narratives and listings;

- generalized program design; and
- overall system design.

b) Updates to all deliverables unless otherwise specified, including the distribution of documentation updates.

2) Post-Implementation Review (PIR)

Review the newly implemented system changes to determine if the delivered product measures up to the expected results. The project is reviewed to determine if the system's operational expectations have been met, the system development effort was performed efficiently, the cost and completion time were within the project estimates, and if the system documentation is satisfactory.

Review shall be done 30 days after the quarter in which the last Operation component was run in production.

Deliverables:

A post-implementation report shall be produced. This report shall identify and explain:

a) How the review was performed, e.g. reports reviewed, screens revised, etc.

b) Significant variances between expected user results and actual system performance;

c) Variance between estimated and actual Design, Development, and Implementation (DD&I) costs;

d) Variance between estimated and actual DD&I schedules;

e) Unanticipated system problems;

f) Variance between implemented system design and design as shown in systems documentation; and

g) Recommendation for remedies for significant deficiencies.

7. State Review and Oversight

The State may monitor any/or all stages of SG development. All deliverables shall be submitted to the State for review and approval, except as otherwise specified in this contract. If the Contracting Officer determines that the Contractor has failed to properly document or implement changes or corrections made to the HCO system(s), the Contractor shall make any necessary corrections at the Contractor's own expense.

3.10.4 Training

3.10.4.1 Overview

The Contractor shall develop and conduct initial and ongoing training programs for the HCO Contractor's staff and monitor staff performance on a continual basis. The training program shall be comprehensive and ensure that Contractor staff is able to diligently perform the scope of work in this Contract.

3.10.4.2 Contractor Responsibilities-Training

1. The Contractor shall maintain the Training Plan developed during Takeover, which includes a training program for all Contractor employees and subcontractors.

   a. The Contractor shall utilize trainers who possess professional and technical skills pertinent to the training program subject matter.

   b. The Contractor shall provide the State with copies of all training manuals and updates.

   c. All Contractor personnel shall successfully complete the training program prior to assuming their duties.

   d. The Contractor shall conduct an annual orientation program to ensure continued staff awareness of HCO Program policies and procedures.

   e. At a minimum, the Training Program shall include:

1) General orientation to the role of the Contractor
2) Orientation to the Health Care Options Program
3) Culturally sensitive materials and activities
4) Enrollment/disenrollment policies, processes, and procedures
5) Problem resolution and grievance policies, procedures, and processes
6) Review of scripts and informing materials
7) A review of plans and services available in each county
8) Overview of State's eligibility process and MEDS
9) Use of all policy, procedure, and reference manuals
10) Customer service standards and phone etiquette
11) Overview of Medi-Cal Managed Care
12) Contractor's Enrollment System
13) Contractor's Telephone System
14) Overview of Quality Assurance policies and manual
15) Security and confidentiality policies
    a) Definition of confidential data and examples of the various types.
    b) Federal and State law pertaining to confidential data.
    c) The Contractor staff's ongoing responsibility to ensure that unauthorized disclosure does not occur, with practical and realistic examples as to how such disclosure can occur and what can be done by all staff to minimize or preclude the occurrence of unauthorized disclosure.
    d) Confidentiality including a script approved by the State to ensure confidentiality guidelines when callers other than the beneficiary are accessing information.
16) Other job duties and functions
17) Fire and safety issues

18) State organization interface

Additional training elements shall be added to the training program by the Contractor as necessary to meet the needs of the specific job classifications used by the Contractor.

2. The Contractor shall conduct, as requested by the State, the HCO education program developed during Takeover for:

   a. County Welfare Department staff
   b. State staff
   c. Consumer advocate groups
   d. Lawsuit representatives
   e. Health plan staff
   f. Local officials
   g. Other parties and organizations impacted by the HCO program and legislation
   h. Community-Based Organizations

3. The Contractor shall make available at each education session, evaluation and/or critique forms for participants to evaluate the training session. The Contractor shall provide a summary of all participant evaluation comments to the State within five business days after each education session. The Contractor shall report all actions taken to correct deficiencies reported on the evaluation forms, and the time frames for accomplishing these actions. The Contractor shall maintain copies of these forms for 90 calendar days, filed by county, by site, and by date.

4. The Contractor shall notify all affected staff of HCO program changes mandated by the State and provide all necessary training prior to their implementation, unless otherwise directed by the State.

5. All training classes and education sessions shall be open to authorized federal, State, and county personnel.

The Contractor shall provide detailed system training on its HCO system to up to 25 State-designated staff per year.

3.10.5 REPORTS

3.10.5.1 Overview

The Contractor shall develop, implement, and maintain a system of records and reports that provide detailed and summary information regarding the HCO program. The Contractor may, as part of the proposal process and during the contract term, suggest modifications to the report formats, as well as additional or revised reports, as it identifies other areas of potential interest to the State.

3.10.5.2 Contractor Responsibilities-Reports

3.10.5.2.1 Daily Status Report

The Contractor shall submit daily status reports to the State. The reports shall meet the following requirements.

1. The report shall be prepared and delivered in a media and format mutually agreed upon by the State and the Contractor, and approved by the State. Three hardcopies and one electronic copy of the reports shall be submitted daily in a media requested and defined by the State.

2. The report shall be submitted no later than 2 p.m. on the first business day following the date covered by the report.

3. The Daily Status Report shall include, but shall not be limited to, the following:

    a. Call Center Activity, including total number of incoming calls; average length of call; average wait time; overall call abandonment rate; abandonment rate by threshold language; voice mail rate; total number of calls answered or transferred; total number of provider calls; total number of outbound calls; total number of all calls; and total number and description of downtime incidents.

    b. Forms Production Activity, including total number of forms received; total number of forms processed; total number of forms and packets returned; total number of incomplete letters; and beginning and ending daily balances. Compute and report the average completion time for both batch and on-line forms processed (both enrollments and disenrollments).

    c. Auto Assignment Summary Report for Medical Beneficiaries assigned to a plan.

    d. Emergency Disenrollment and Exemption Activity; including number of exemption requests received; number of requests processed (number of approved requests processed prior to

enrollment, number of approved requests processed which resulted in a disenrollment, and number of denied requests); number of expedited (emergency) disenrollment requests received; number of expedited (emergency) disenrollment requests processed (number of requests processed as approved and number denied); number of retroactive disenrollment requests received; number of retroactive disenrollment requests processed (number of requests processed as approved and number denied); and beginning and ending balances. Compute and report the average completion time for expedited disenrollment, exemption and retroactive disenrollment forms processed.

e. Daily Data Entry transactions sent to MEDS including enrollments and disenrollments and Fee for Service transactions.

f. Daily Records Sent and Received Report for each mail distribution facility. Reports to include the records sent to and received by the mail facility by type, as follows: Intent to Assign, Intent to Default, Confirmation, Disenrollment and Renotification letters; and packet requests. Compute and report the sent and received times.

g. Daily Letters Mailed Report, for Medical and Dental, for each mail facility. Reports to include letters and/or packets mailed by type, and by county as follows: Intent to Assign, Intent to Default, Confirmation and Disenrollment letters; packet requests; outreach; special mailings; post card mailings by Medical and Dental and a daily total. Compute and report the mailing time

h. Significant issues should be identified and discussed.

3.10.5.2.2 Weekly Narrative Report

The Contractor shall submit weekly narrative reports to the State. The reports shall meet the following requirements:

1. The report shall be prepared and delivered in a media and format mutually agreed upon by the State and the Contractor, and approved by the State. At a minimum three hardcopies and one electronic copy of the reports shall be submitted weekly in a media requested and defined by the State.

2. The report shall be submitted no later than the third business day

following the report week.

3. The Weekly Narrative Report shall include, but not be limited to, the summary of accomplishments and issues for project operations, as follows:

   a. Weekly compilation of Call Center activities identified in the Daily Status Reports, documentation of downtime and/or unusual incidents, number of calls answered and resolved during the initial telephone contact, number of call-backs that were resolved within one business day; number of calls and voice messages not resolved within one business day; and number of calls referred to the Research Unit.

   b. Weekly compilation of enrollment/disenrollment processing operations identified in the Daily Status Reports, including the weekly compilation of computed completion times.

   c. Weekly highlights of enrollment services activities including outreach and education events and issues relating to outreach activities.

   d. Weekly summary of mail functions that include significant changes, Quality Assurance activities, and issues related to mail operations.

   e. Identification of special interest issues (new, outstanding, needing resolution, etc.).

   f. Timeliness and accuracy of weekly reports to managed care plans.

   g. Identification of providers who have requested more than 25 exemptions and the beneficiaries that have requested them, regardless of time frame.

4. Weekly Inventory Production Reports shall include, but not limited to:

   a. Inventory on hand

   b. Inventory usage

   c. Outstanding inventory on back order

   d. Report on inventory to be replenished

e. Daily production reports

3.10.5.2.3 Monthly Reports

The Contractor shall submit monthly reports to the State. Reports shall be prepared and delivered in a media and format mutually agreed upon by the State and the Contractor, and approved by the State. At a minimum, three hardcopies and one electronic copy of the reports shall be submitted monthly in a media requested and defined by the State. Reports shall be submitted by the tenth business day following the report month, unless otherwise specified herein. The reports shall be prepared to meet the following requirements:

1. The Contractor shall submit to the State a Monthly Progress Report, which shall include, but not be limited to, the following:

   a. Table of Contents

   b. Monthly Report Summary

      1) Summary of all activities reported daily as noted in Daily Status Report, above.

      2) Summary of training activities.

      3) Summary of Supervisor monitoring activities for forms processing and telephone call center.

   c. A computation reflecting levels of performance for all contract requirements and to include a 12 month running history.

   d. HCO Status reports, by county

      Inter-county reports shall compare county performance at HCO presentations. Reports shall be summarized by the location and overall county total and separated by Medical and Dental.

      1) Summary of supervisor monitoring of field activities, including monthly performance indicators by region and county.

      2) A daily and monthly total, by county, of the number of presentations made at each location and total length of each presentation. A presentation is considered complete when all information available in the approved script is provided to the persons recorded as attending

the presentation.

3) A daily and monthly total, by county and location, of the number of persons that actually attended the HCO presentation, and the number of Medi-Cal cases represented by those persons, including both intakes and redeterminations.

4) A daily and monthly total, by county and location, of the number of persons referred to Customer Assistance who did not attend a presentation. Customer Assistance includes answering questions, referrals to health plans or the telephone call center, assistance with forms and other HCO activities provided when the person has not attended a presentation.

5) A daily and monthly total, by county, of the number of Medi-Cal cases referred to HCO presentations in counties that utilize a referral process and referral forms.

6) Incidence of the number and percentage of persons who chose specific health care plans at the time of the presentation, including the name of the plan, and fee-for-service, by county.

7) A summary total, by county, location and plan, of the number of persons requesting disenrollment and the reasons for the requests for disenrollment.

8) Average length of time enrolled in the most recent plan, by county, by plan.

9) Total applications completed by case number and number of persons; total applications granted by case number and number of persons.

10) Number and percentage of persons who choose Fee For Service (separated by new eligibility and redetermination)

e. Narrative report, including an overview of current and future activities, any pertinent information not included in statistical information and an explanation of variations in the statistical information.

f. Any other reports and information as determined and requested by the State, such as specialized research reports, shall be

included in the Monthly Progress Report.

g. A summary of exemption processing

2. The Contractor shall submit to the State a Monthly Quality Assurance Report in accordance with requirements in Monthly Quality Assurance Performance Report.

3. The Contractor shall submit to the State a monthly Presentation Progress Report that includes, but is not limited to, the following:

   a. A monthly summary, by county and location, of individual Enrollment Services Representatives' time spent at each presentation location with full-time equivalent (FTE) calculations for each ESR.

   b. Schedule for the following month including ESR, event or organization served, location, date/time, anticipated number of attendees and Contractor's proposed ESR FTE level.

   c. A summary of all beneficiary evaluation comments collected during the month. The Contractor shall report all actions taken to correct deficiencies identified as a result of the evaluations, and the time frames for accomplishing these actions.

   d. A summary, by ESR, of the Contractor's HCO presentation monitoring observation/evaluation comments collected during the month. The Contractor shall report all actions taken to correct deficiencies identified as a result of the evaluations, and the time frames for accomplishing those actions.

   e. The number of plan choices being made by applicants and beneficiaries at the presentation sites immediately following a presentation.

   f. A summary of the activities, statistics, and evaluations of the outreach and enrollment assistance sessions.

4. The Contractor shall submit to the State Problem Statement Status Reports no later than the tenth business day of each month for activity occurring in the previous month. An exception is the monthly Problem Statement Disposition Report, which must be mailed to the health care plans and the State by the fifth business day of each month for the previous month's reporting. The Problem Statement Status Reports shall serve as a joint tracking system; therefore the State shall retain the right to approve/disapprove the information provided by the

Contractor on a report-by-report basis. When information has been disapproved, the Contractor shall revise and resubmit the status reports to the State within five business days. The reports shall provide, at a minimum:

a. Problem Statement Internal Tracking Report that includes a detailed list of all open and closed problem statements

b. Problem Statement Internal Tracking Report – Open only that includes a detailed list of all open problem statements

c. Problem Statement Disposition Report includes a detailed list of all open problem statements sorted by county, in a format agreed upon by the State.

d. Problem Statement Summary Report includes a summary of problem statement activity, including current monthly and year-to-date categories and aging and timeliness information.

e. Problem Statement Aging Report includes a list of the problem statements that have exceeded the applicable contractually required time frames, as stated in this section. The Contractor shall include a correction action plan that addresses each problem statement in the report.

5. The Contractor shall submit to the State the following additional monthly reports, in an agreed-upon format, no later than the first business day of each month:

a. Monthly Enrollment Summary – County/Plan (Data Library reference existing report MSC-B-M02).

b. HCO Disenrollments by Reason Summary (Data Library reference existing report MSC-B-M04).

c. Disenrollment by Reason and Plan Reports (Data Library reference existing report MSC-B-M05). Also include new reports that include Dental.

6. The Contractor shall submit to the State a Records Retrieval Performance Report, in an agreed upon format, no later than the fifth business day of each month. This report shall include, at a minimum, the following information for total unduplicated requests for each type of record requested:

a. Total number of copies requested.

b. Total number of copies delivered.

c. Total number of copies delivered late.

d. Total number of copies not delivered.

e. Number of undelivered requests and the reasons for no delivery.

The monthly performance report shall summarize the above information for those records requested during a month. For those records that are delivered late or are not delivered, the report shall list the type of record, the document number(s) or names(s) (e.g., the number or name by which the record was retrieved) of each requested document, the number of days late in delivery, and the reason for each delay or non-delivery.

For those records not delivered, the report shall show the number of days outstanding beyond the delivery date for each requested document number or name. Records not delivered during the report period shall be listed on each subsequent monthly report until such documents are delivered. Summary data shall be included for each of the categories. This report shall be attached to each monthly payment invoice that the Contractor submits to the State and shall meet the retrieval standards established by the Contracting Officer. The monthly performance report may be modified at the discretion of the Contracting Officer.

7. The Contractor shall submit to the State the following additional monthly reports, in an agreed upon format, no later than the tenth business day of each month:

a. Beneficiary Status Counts by County (Data Library reference existing report MSD-B-M24).

b. Approved Emergency Disenrollments by Reason & Plan - spreadsheet format (Data Library reference existing report MSC-B-M27).

c. Approved Emergency Disenrollments by Reason & Plan (Data Library reference existing report MSC-B-M28).

d. Medical Exemption Summary Report (Data Library reference existing report MSC-B-M29).

e. Defaults by County, ZIP, And Language report (Data Library reference existing report MSC-B-M30).

f. Disenrollments by County, ZIP, And Language Report (Data Library reference existing report MSC-B-M31).

g. Include new reports for Dental.

h. Other reports, as designed by the previous Contractor's subcontractor, as prioritized and directed by the State (Data Library)

i. Exemption Request by Reason and County Medical Exemptions (Data Library reference existing report MSC-B-M34).

j. Accepted Exemptions Prior to Enrollment by Reason and County Medical Exemptions (Data Library reference existing report MSC-B-M38).

k. Enrollment Dental Summary (Data Library reference existing report MSC-B-M02D).

l. Disenrollment By Reason & Plan Dental (Data Library reference existing report MSC-B-M05D).

m. Status of Remaining Eligables in Mandatory Aid Code Eligible ot Receive Dental Enrollment Mailing (Data Library reference existing report MSC-B-M13D).

n. Auto Assignment Summery Report For Dental Beneficiaries Assigned To Plan (Data Library reference existing report MSC-B-M23D).

o. Approved Emergency Disenrollments By Reason & Plan Dental (Data Library reference existing report MSC-B-M27D).

p. Medical Exemption Dental Summary (Data Library reference existing report MSC-B-M29D).

q. Defaults by County, Zip & Language Dental MEDS Accepted (Data Library reference existing report MSC-B-M30D).

r. Disenrollments By County, Zip & Language Dental MEDS Accepted (Data Library reference existing report MSC-B-M31D).

s. Exemption Requests by Reason and County Dental Exemptions

(Data Library reference existing report MSC-B-M34D).

t. Accepted Exemptions Prior to Enrollment by Reason and County Dental Exemptions (Data Library reference existing report MSC-B-M38D).

8. The Contractor shall submit to the State other reports, to include but not limited to the following:

   a. Access to and report run capability of all on-line ad hoc reports.

   b. Monthly Mandatory Eligibles Report due within two business days after reconciliation (Data Library reference existing report MTC-B-M13).

   c. Monthly Status of Exemptions Expiration Reports identifies the current status of exemptions due to expire with in the next 90 days. This report shall be sorted by county and by month of expiration.

9. An inventory report of all HCO informing materials with on-line read only print capabilities.

3.10.5.2.4 Reports to Managed Care Plans

1. The Contractor shall submit lists or files, on a weekly basis, directly to the managed care plans regarding those beneficiaries who have been enrolled in and disenrolled from the managed care plan and the PCP selected by the beneficiary (if applicable) through the HCO program.

   a. The reports shall include all information provided on the form, e.g., beneficiary name, Social Security Number, address, pregnancy information, etc.

   b. A copy of the weekly report to the plans shall be sent to the State in a format and media approved by the State.

2. On a weekly basis, the Contractor shall report to each applicable plan the past week's packet mailings for each county in which the plan has a Medi-Cal Managed Care contract. A copy of the weekly report to the plans shall be sent to the State in a media and format approved by the State.

3.10.5.2.5 Ad Hoc Reports

1. The Contractor shall provide any ad hoc reports as requested, and within the time frame designated by, the State. These reports do not include those described elsewhere in Reports, and shall be reimbursed as specified in Cost Reimbursement Categories. The number of requests will vary on a monthly basis.

2. The Contractor shall retain the ability to re-generate ad hoc reports developed pursuant to requirements in Ad Hoc Reports, so reports maybe re-run at a future date upon request.

3.10.6 CONTRACTOR RESPONSIBIILTIES-RECORDS RETENTION AND RETRIEVAL

3.10.6.1 Overview

The State makes a clear distinction between (a) the Contractor's corporate or business financial records and (b) Medi-Cal Health Care Options (HCO) program records. Rules governing the maintenance and disposition of corporate financial records are contained in Terms and Conditions, Access Requirements (Section 6.47). Records Retention and Retrieval governs the Contractor's responsibilities for Medi-Cal HCO records.

3.10.6.2 Contractor Responsibilities-Records Retention and Retrieval

The Contractor functions as the custodian of records for the HCO program. The Contractor shall:

1. Maintain these records.

2. Produce copies of these records when required.

3. Provide access to records for authorized State and federal employees.

4. Retrieve records upon request and certify the authenticity of records retrieved.

5. Produce regularly scheduled reports on records requested.

6. Maintain a Records Retention Procedures Manual for use by Contractor and State employees, and update the manual when changes occur or at least annually.

7. Purge, with prior State approval, records that exceed required retention periods.

8. Transfer HCO records to a subsequent contractor, via the State, upon termination of this contract.

3.10.6.3 Objectives

The objectives of the Records Retention requirements are to:

1. Establish that custodianship of Medi-Cal HCO records lies with the Contractor.

2. Assure that the Contractor maintains the ability to produce acceptable hard copies of HCO records upon request.

3. Guarantee that authorized State and federal employees shall have access to necessary HCO records.

4. Assure that the Contractor shall retrieve and deliver HCO records upon request and in a timely manner.

5. Provide for a system of certifying the authenticity of Medi-Cal HCO records.

6. Provide Contractor, State and federal employees with clear guidelines and instructions for interacting with the Contractor on records retention issues.

3.10.6.4 Assumptions and Constraints

In establishing the requirements of this section, the State makes the following assumptions and constraints:

For purposes of this section, “HCO records” shall include, but not necessarily be limited to:

a. Enrollment/Disenrollment forms

b. Medical/Non-medical Exemption forms

c. Beneficiary correspondence

d. Health plan correspondence

e. Any other forms, attachments, letters or reports that are a part of, produced from, or generated as a result of the Contractor’s Medi-Cal HCO program activities.

f. All Medi-Cal HCO records transferred from the prior contractor and the State. The Contractor shall store and be able to retrieve this data.

g. Customer Service Representative Incident reports.

The Contractor shall be capable of maintaining, accessing and retrieving HCO records and data for a period of ten years from the date of their origin, and be able to retrieve the data for State, federal or Contractor usage.

The Contractor may propose (at no additional cost to the State) to store the HCO records and data on appropriate long-term storage media. If the Contractor proposal is accepted by the State, the Contractor shall comply with the standards and requirements in Security and Contractor Responsibilities – Confidentiality (Subsection 3.8.2).

3. The Contractor shall retrieve all HCO records within three business days of the date of a State request. All copies shall be clear and legible and shall include all attachments.

4. The State may annually request hard copy reproductions of up to 10,000 HCO records per contract year under this section.

3.10.6.5 Custodian of Records

The Contractor shall serve as the custodian of all Medi-Cal HCO records under the Contractor's possession and control. Contractor custodial responsibilities shall include, but not be limited to, the following:

1. The Contractor shall preserve, protect and maintain all Medi-Cal HCO records that are a part of, or result from, the Contractor's operations under this contract. throughout the life of this contract. Records that have been involved in matters in litigation shall be kept for a period of not less that three years following the termination of such litigation, regardless of the expiration or termination of this contract.

2. The Contractor shall preserve and protect all Medi-Cal HCO records transferred to it from the preceding contractor and the State.

3. As custodian of records, the Contractor shall respond to all SUBPOENA DUCES TECUM served on either the Contractor or the State for documents in possession of the Contractor. The Contractor shall ensure that deadlines set by the court for responding to SUBPOENA DUCES TECUM are met, and that, when necessary, expert witness testimony regarding the named records shall also be provided within the court's deadlines. This provision shall also apply in

cases in which the court requires testimony and documents regarding HCO records that were collected or processed under a prior contract that are now in the Contractor's possession.

4. The Contractor shall notify the State prior to or concurrent with responding to SUBPOENA DUCES TECUM, and/or the delivery of all expert witness testimony.

5. The Contractor may dispose of records under its custodianship only after receipt of written approval from the Contracting Officer of the time, place, method of disposal, and specific records or group of records to be destroyed.

6. The Contractor shall develop and submit for written approval by the Contracting Officer a Records/Files Summary, including a brief description of all records and/or files maintained under this contract. The initial Records/Files Summary shall be delivered to the State six months after the contract effective date. Upon approval of the Contracting Officer, the summary shall be maintained, updated, produced, and resubmitted to the State for approval on a quarterly basis.

7. Microfilm/microfiche may be substituted for original HCO documents or records. Other form of State-approved reproduced copies may be substituted for originals at the discretion, and with prior written approval, of the Contracting Officer during the life of this contract under the following conditions:

    a. The Contractor shall preserve, protect, and maintain original documents for a minimum period of 60 days after their reproduction unless required differently and in writing by the Contracting Officer.

    b. Microfilm/microfiche copies of HCO documents or records shall meet the following standards and requirements:

        1) All microfilm/microfiche shall be produced in a manner as outlined by the National Micrographics Association standards for the industry (standards, MSI 1971 and standards, MS2 1971).

        2) The original silver halide film shall be of archival quality as described by ANSI-PH 1.25 and ANSI-PH 1.28 or ANSI-PH 1.41.

3) The standard density shall meet the negative density standard (for master silver film) determined by the State as 0.8 and 1.3.

4) The line density and character density shall have a .06 through a .09 maximum density.

5) The ANSI-PH 4.8 standard for residual hypo shall be met. Independent laboratory tests shall be conducted at least annually and the results of these tests shall be delivered to the State within 15 business days after completion.

6) Duplicates, or copies, shall be of appropriate density that is clearly readable. Clearly readable shall be defined as to be acceptable as evidence in court of law (Evidence Code, Section 1500 et seq.), and shall meet the requirements of Government Code, Section 14756. First generate film shall be maintained for a state approved period of time in order to facilitate microfilm/microfiche duplication.

7) A silver halide copy of microfilm/microfiche shall be stored in accordance with ANSI-PH 1.43. Silver halide microfilm/microfiche may not be stored with diazo or other types of microfilm/microfiche.

8) Inspection procedures shall be established to monitor overlapping of documents, clarity of images, edge warping, illegible characters, blisters, processing stains, scratches, finger marks, etc. The inspection and Quality Assurance procedures shall be at least equal to the National Micrographics Association's standard MS-104, "Inspection and Quality Control of First Generation Silver Halide Microfilm."

9) Microfilm/microfiche may be substituted for original HCO Medi-Cal documents. To ensure availability and compliance with Microfilm/microfiche standards, original documents must be retained for a minimum period of 90 days after their reproduction. After 90 days, the documents may be purged and confidentially destroyed.

10) The State shall reserve the right to run any test at any time the State deems appropriate to assure the above standards are being met.

11) All other requirements specified for Records Retention and Retrieval not specifically modified for microfilm/microfiche remain in effect.

12) Any additional storage or maintenance costs incurred by the Contractor under this provision shall be the sole responsibility of the Contractor; the State shall not provide reimbursement to the Contractor for such additional storage costs.

3.10.6.6 Access, Retrieval and Certification

The Contractor shall provide authorized access to, retrieval services for, and certification of Medi-Cal HCO records under its custodianship during the life of this contract and in compliance with the following conditions:

1. A document, for retrieval purposes, includes all attachments.

2. In keeping with the security provisions of this contract, the Contractor shall establish and maintain procedures for allowing authorized State and federal employees, agents, or representatives access to all Medi-Cal HCO records held under the custodianship of the Contractor. These access procedures shall be subject to State review, written approval, and modification.

3. The Contractor shall establish and maintain procedures for retrieving Medi-Cal HCO records requested by the State. These procedures shall be included in the Records Retention Procedures Manual and shall be subject to State review, written approval, and modification.

4. The Contractor's procedures shall provide for the following:

   a. A minimum of ten years of records for requirements b. through d. shall be subject to these retrieval procedures.

   b. Beneficiary enrollment/disenrollment forms shall be retrievable by document control number (DCN), beneficiary identification number, beneficiary Social Security Number (SSN), or Medi-Cal Eligibility Data System (MEDS) ID number.

   c. Correspondence to and from beneficiaries and health plans shall be retrievable by beneficiary name and beneficiary number, or the name of their authorized representative.

d. Attachments to enrollment/disenrollment forms or other documents shall be retrievable by DCN.

e. The location of all records under the Contractor's custodianship shall, for purposes of retrieval and accessibility, be listed in a Master Index, which shall be updated and made available to the State monthly.

f. Unless otherwise specified in writing by the State, a single copy of all requested document copies shall be provided on paper.

g. Requests for which no documents are retrieved shall be returned with an explanation from the Contractor. At a minimum, the explanation provided shall include:

- "Document not on file" or
- "Invalid document number"

h. Document copies shall be delivered to local users or mailed to users located more than 30 miles from the State capitol building in Sacramento no later than three business days following the date the request is received by the Contractor.

5. The Contractor shall establish, maintain, and update as necessary procedures for certifying the accuracy and authenticity of original HCO program records. The Contractor shall only be required to certify that hard copies of records received from the prior contractor are in fact copies of records transferred from the prior contractor to the current one. Certification procedures shall be subject to state review, written approval, and modification, and these procedures shall be included as a separate section or chapter of the Records Retention Procedures Manual.

6. In addition to the responsibilities contained in this section, the Contractor shall provide all necessary assistance to the State in the identification, retrieval, and certification of Medi-Cal HCO records and any other requested information for the purposes of the investigation, prosecution, or defense of Medi-Cal related cases. Such cases may include, but are not limited to, Notices of Dispute filed by health plans, denials of exemption requests, and actions against the State. The State shall have the authority to review, approve in writing, and modify the procedures, steps, or other services by which the Contractor attempts to comply with this requirement.

7. The Contractor shall be responsible for replying to all other requests for Medi-Cal HCO records by parties other than the State when such requests have been submitted to the Contractor in the form of a SUBPOENA DUCES TECUM. The Contractor shall perform this service as part of its custodianship responsibilities. The State shall provide no additional reimbursement to the Contractor for the provision of this service. The Contractor may, however, request payment for such services from the court or the party issuing the subpoena.

8. The Contractor shall maintain accurate records of all document/record retrieval requests in accordance with this subsection and requirements of Security and Confidentiality.

3.10.6.7 Reporting Requirements

1. Records Retrieval Performance Report

   The Contractor shall produce and deliver to the State by the fifth State business day of each month a Records Retrieval Performance Report. The report shall include, at a minimum, the following information for total unduplicated requests for each type of record requested:

   a. Total number of copies requested.

   b. Total number of copies delivered.

   c. Total number of copies delivered late.

   d. Total number of copies not delivered.

   e. Number of undelivered requests and the reasons requests were undelivered.

   The monthly performance report shall summarize the above information for those records requested during a month. For those records that are late in delivery or are not delivered, the report shall list the type of record, the document number(s) or name(s) (e.g., the number or name by which the record was retrieved) of each requested document, the number of days late in delivery, and the reason for each delay or non-delivery.

   For those records not delivered, the report shall show the number of days outstanding beyond the delivery date for each requested document number or name. Records not delivered during the report period shall be listed on each subsequent monthly report until such documents are delivered. Summary data shall be included for each of

the categories. This report shall be attached to each monthly payment invoice submitted by the Contractor to the State and shall meet the retrieval standards set by the Contracting Officer. The monthly performance report may be modified at the discretion of the Contracting Officer.

2. Records/Files Summary

   a. The Contractor shall develop and deliver to the State a Records/Files Summary, including a brief description of all records and/or files maintained under this contract.

   b. The summary shall include, at a minimum, the name of the record or file, the medium of retention (hard copy, tape, etc.), duration (how long the record or file is maintained in the defined media), disposition (subsequent arrangements for retention or purge), and access (the methodology necessary to gain access to the record or file). The summary shall be updated and produced on a quarterly basis.

3.10.6.8 Records Retention and Retrieval Procedures Manual

The Contractor shall prepare, update, and maintain a Records Retention and Retrieval Procedures Manual that thoroughly describes the specific steps to be followed to carry out the Contractor's records retention and retrieval responsibilities. This manual shall be designed and written for the use of both Contractor and State staff, and shall be submitted for State review and approval during Takeover, in accordance with the provisions of Takeover Requirements.

The manual shall be reviewed and amended by the Contractor as necessary but in no case less than annually to accurately reflect any changes in the Contractor's records retention and retrieval procedures. Copies of all procedure or manual amendments shall be delivered to the Contracting Officer for review and written approval prior to publication and distribution.

3.10.6.9 Transfer on Termination

The Contractor shall, upon termination of this contract, transfer control of all Medi-Cal HCO records under its custodianship to a successor contractor or the State. The State shall retain the authority to designate the manner and method by which HCO records shall be transferred. The State may exempt from transfer those records necessarily retained by the Contractor for litigation purposes.

3.10.6.10 Deliverables

In addition to responding to any State or State-approved requests for copies of Medi-Cal HCO records, the Contractor shall:

1. Update the Records Retention and Retrieval Procedures Manual annually and in addition as necessary, with prior State approval.

2. Maintain the Records/File Summary and update quarterly.

3. Maintain the Master Index and update monthly.

4. Compile document requests into a monthly Records Retrieval Performance Report.

5. Notify, respond to, and provide a copy of any Supoena Duces Tecum.